



EMPLOYEE BENEFITS *Guide*



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26



CITY OF
HERMOSA BEACH

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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 36 for more details.

The information in this brochure is a general outline of the benefits offered under City of Hermosa Beach's 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.

2026 Benefit Plan Overview



Cigna Medical

Cigna will continue to be the City's health plan partner, with medical, pharmacy, and behavioral health benefits all in one plan.

With Cigna Healthcare, you have access to resources to help ensure you get the right care at the right time and for the lowest cost under your plan.

To help you get the most out of your health plan, you'll first need to understand how to access all of the great resources available to you. That's where the Cigna Healthcare Virtual Benefits Education Website comes in. The [Cigna Education site](#) includes:

- Resources on getting the most from your plan, understanding your pharmacy benefits, and determining which virtual and digital care options you can access. This section also includes a handy dictionary to help you understand some of the most common health care terms.
- Details on the benefits and coverage including what it will cost you to receive care.
- Information on resources and programs Cigna Healthcare offers, including how to access our One Guide® concierge service.
- Need more help, call the Cigna Pre-enrollment Hotline at [888-806-5094](tel:888-806-5094).

LifeMatters® – Employee Assistance Program!

The City's Employee Assistance Program is called LifeMatters. You, your eligible dependents, and anyone residing in your household can call LifeMatters 24/7 to receive EAP services. Each eligible member has six face-to-face counseling sessions per issue, per year. See page 22 for additional information.

Additional access to services is available at www.lifematters.com; password CHB1.

If you have any questions about this confidential service, call LifeMatters at [800-367-7474](tel:800-367-7474).

ScholarShare529 Workplace Savings

ScholarShare529 is a nationally-recognized college savings plan that can help your family save for future college costs. Benefits of the program include tax benefits, flexibility, and low fees. See page 27 for more information.

Enroll anytime at www.ScholarShare529.com or call [800-544-5248](tel:800-544-5248).

Dental, Vision, Life, Disability and Voluntary Benefits – No Changes to Plans or Rates!

The City will continue to offer the following plans with no changes to the benefits.

- Ameritas Fusion PPO Dental
- Liberty Dental HMO
- Mutual of Omaha Basic Life/AD&D, Short-Term Disability, Long-Term Disability, and Voluntary Life/AD&D
- Colonial Voluntary Benefits

Open Enrollment

If you don't want to make any changes, you may default to the same coverage you elected last year. However, you will not automatically be enrolled in any Flexible Spending Accounts - you need to make a new election each year to participate.

Self-Serve Open Enrollment In Ease

Employees may complete their enrollment through the Ease self-serve enrollment platform at www.hermosabeach.ease.com.

Benefits At A Glance



Your benefits are an important part of your overall compensation. We are pleased to offer a comprehensive array of quality benefits to protect your health, your family and your way of life. This enrollment guide was designed to answer some basic questions you may have about your benefits. Please read it carefully along with any supplemental materials you receive. If there is a discrepancy between the summaries and the written legal plan documents, the plan documents shall prevail.

Benefits

Medical (1/1/26 - 12/31/26)

- Cigna Select HMO*
- Cigna Full HMO*
- Cigna Open Access Plus (PPO)

Dental (1/1/26 - 12/31/26)

- Liberty Dental HMO*
- Ameritas Fusion PPO

Vision (1/1/26 - 12/31/26)

- Ameritas (VSP & EyeMed) Vision

Life & AD&D

- Mutual of Omaha Life & AD&D**

Short-Term Disability (1/1/26 - 12/31/26)

- Mutual of Omaha**

Long-Term Disability (1/1/26 - 12/31/26)

- Mutual of Omaha**

Additional Benefits

- Healthcare Flexible Spending Account
- Dependent Care Flexible Spending Account
- Colonial Voluntary Benefits
- Employee Assistance Program

* Only available to residents of California

** Based upon Employee's Memorandum of Understanding (MOU)

Who's Eligible for Benefits?

Employees

You are eligible for benefits if you are an active full time employee.

Dependents

The City offers health care coverage (medical, dental, and vision) to all benefit-eligible employees and their eligible dependents. Employees are permitted to cover

eligible dependents of their choosing under any of these plans in which they themselves enroll. Additionally, the dependents whom you choose to enroll need not "match" across plan type. For example, you may choose to enroll your spouse in dental coverage but not in medical, or your child in dental coverage, but not in vision.

Eligible Dependents Include:

- **Your spouse** – The person who you are legally married to under state law, including a same-sex spouse.
- **Your registered or non-registered domestic partner** - Any premiums for your domestic partner paid for by the City of Hermosa Beach are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- **Your child(ren) – Includes natural children, step-children, domestic partner's children, adopted children, children fostered under legal custody, and children covered under legal guardianship:**
 - Under age 26. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
 - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support. See below regarding Disabled Dependents for additional information.
 - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.
- **Disabled Dependent** – A disabled dependent child may be eligible for health benefits beyond the age of 26. A disabled dependent can remain a qualified dependent if the disability is certified by a physician and if it occurred prior to reaching age of 26. Contact the carriers' member services department for the Disabled Dependent Certification Form.



Eligible dependents do not include your sibling or someone else's child (such as your nieces or nephews) unless you have legal custody or guardianship, parents, parents-in-law, or grandparents, regardless of their IRS dependent status.

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

When Coverage Begins

For new employees, coverage is effective on the first of the month following date of hire. If you fail to enroll on time, you will NOT have benefits coverage. Changes made during our annual Open Enrollment period are effective on January 1st.

When can I enroll?

You have 30 days from your date of hire to enroll into benefits. For new employees, coverage is effective on the first of the month following date of hire. If you fail to enroll on time, you will NOT have benefits coverage.

You may make changes to your benefits during the once-a-year Open Enrollment period, or if you experience a mid-year qualifying life event (see table below for reference). Make sure to notify Human Resources right away if you have a qualifying life event and need to make a mid-year enrollment change.

If you do not enroll within 30 days from date of hire, you will be automatically enrolled in the following employer-paid plans: Employee Assistance Program, Basic Life and AD&D Insurance, Short-Term Disability, and Long-Term Disability if applicable per the MOU.

Qualifying Life Events, include (but are not limited to):	Time you have to make a benefit change
Birth or adoption of a baby or child	30 days
Marriage	30 days
Loss of other healthcare coverage	30 days
Loss of Medicaid or Children's Health Insurance Program (CHIP)	60 days
Eligibility for new healthcare coverage	30 days
Divorce	30 days

Dependent Verification

Adding a dependent is subject to verification to ensure they are eligible to participate in our plans. You may be required to provide proof of one or more of the following:

- Marriage Certificate or License.
- Domestic Partner Affidavit.
- Birth Certificate (hospital certificates are not official birth records and will not be accepted as proof of birth).
- Final decree of divorce.
- Court documents showing legal responsibility for adopted children, foster children, and children under legal guardianship.
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support).
- Additional documentation such as tax returns or utility bills to demonstrate dependent eligibility may be requested.

Have Questions about Your Benefits?

If you need assistance understanding your benefits or finding a provider, you may contact the following:

Cigna

- Cigna Pre-enrollment Hotline: [888-806-5094](tel:888-806-5094)
- Cigna Education site: benefitseducationcigna.com

Keenan & Associates

- Andrea Estrin: [949-940-1760](tel:949-940-1760) ext. 5133, email: aestrin@keenan.com
- KelseyMarie White: [951-715-0190](tel:951-715-0190) ext. 1123, email: kwhite@keenan.com
- Kimberly Gleeson: [949-940-1760](tel:949-940-1760) ext. 5175, email: kgleeson@keenan.com

Which Plan is Right For You?



Health Maintenance Organizations (HMOs)

The HMOs require in-network providers and allow you to receive comprehensive coverage at set prices, called copays.

- **Doctors/Other Medical Care Providers:** You can only use doctors, hospitals, and pharmacies that participate in the HMO network. Doctors who participate in the HMO network are called in-network providers. There is no coverage if you go to out-of-network providers, except for emergency services.
 - **Annual Deductible:** You don't need to pay an annual deductible before the plan begins to pay for a portion of covered medical services.
 - **Copays:** When you receive medical care, you pay a set dollar amount called a copay.
 - **Annual Out-of-Pocket Maximum:** The HMO plans include an annual out-of-pocket maximum. This is the maximum amount you must pay out of your own pocket for copays during the plan year. Once you reach the out-of-pocket maximum, the plan pays 100% of covered charges for the remainder of the plan year.
 - **Preventative Care:** Preventative care is 100% covered.
- Consider an HMO (Health Maintenance Organization) if:**
- You want lower, predictable out-of-pocket costs.
 - You like having one doctor to manage your care.
 - You are happy with the selection of network providers.
 - You don't see any doctors that are out-of-network.

Open Access Plus (PPO)

The OAP plan allows you to use any provider you want.

- **Doctors/Health Care Providers:** You can choose any doctor you want, and you can go to any hospital or facility. However, you'll pay less when you use a provider or facility that participates in Cigna's OAP network.

- **No-referral specialist care:** A primary care provider (PCP) is recommended but not required. If you need to see a specialist for any reason, you don't need a referral to see an in-network health care provider. If you choose an out-of-network specialist, your care will be covered at the out-of-network level, and you may be responsible for any preauthorizations needed.
- **Care Coordination:** Cigna's medical management program provides you and your family a valuable resource for one-on-one support and guidance to the right programs and services.
- **Preventive Care:** Preventive care is 100% covered when you use in-network providers.
- **Annual Deductible:** You generally pay an annual deductible before the plan begins to pay for a portion of covered medical services.
- **Paying for Care:** When you receive medical care, there are two ways you pay for services:
 - **Copays:** When you go to an in-network doctor for an office visit, go to the emergency room, or pick up a prescription, you pay a set dollar amount called a copay. (You may need to pay the annual deductible first before the copay applies.)
 - **Coinsurance:** When you receive any other medical services, you pay a percentage of the cost of the service, and the plan pays the remaining percentage. This is called coinsurance. (You may need to pay the annual deductible first before coinsurance applies.)
- **Annual Out-of-Pocket Maximum:** The OAP includes an out-of-pocket maximum. This is the maximum amount you must pay out of your own pocket (under the applicable coinsurance percentage) after meeting the deductible. Once you reach the out-of-pocket maximum, the plan pays 100% of in-network charges for the remainder of the plan year. Please note that your out-of-pocket maximum will be lower when you use in-network providers. If you receive out-of-network care, your costs will be higher. Out-of-network providers and facilities may also bill you for charges that are not covered by the plan. Charges not covered by the plan do not contribute to your deductible or out-of-pocket limits.

Consider the OAP (Preferred Provider Organization) if:

- You want to be able to see any provider, even a specialist, without a referral.
- You are willing to pay more to see out-of-network providers

Employee Costs - Medical



2026 Medical	Monthly Premium	Teamsters, P&AE, Unrepresented		Police		Management, City Council, City Treasurer	
		City Portion	Employee Portion	City Portion	Employee Portion	City Portion	Employee Portion
Cigna Select HMO							
Emp. Only	\$749.78	\$749.78	\$0.00	\$749.78	\$0.00	\$749.78	\$0.00
Emp. +1 Dep	\$1,379.60	\$1,379.60	\$0.00	\$1,379.60	\$0.00	\$1,379.60	\$0.00
Emp. +2/More	\$1,874.45	\$1,874.45	\$0.00	\$1,874.45	\$0.00	\$1,874.45	\$0.00
Cigna Full HMO							
Emp. Only	\$987.29	\$987.25	\$0.00	\$987.25	\$0.00	\$987.29	\$0.00
Emp. +1 Dep	\$1,816.60	\$1,816.60	\$0.00	\$1,816.60	\$0.00	\$1,816.60	\$0.00
Emp. +2/More	\$2,468.22	\$1,875.39	\$592.83	\$1,931.04	\$537.18	\$1,875.39	\$592.83
Cigna OAP (PPO)							
Emp. Only	\$964.24	\$964.24	\$0.00	\$964.24	\$0.00	\$964.24	\$0.00
Emp. +1 Dep	\$1,774.68	\$1,774.68	\$0.00	\$1,774.68	\$0.00	\$1,774.68	\$0.00
Emp. +2/More	\$2,411.26	\$1,875.39	\$535.87	\$1,931.04	\$480.22	\$1,875.39	\$535.87



Cigna HMO Plans



We offer medical and prescription drug benefits through Cigna. With an HMO plan, you select a Primary Care Physician from the participating network of providers who will coordinate your healthcare needs including referrals to specialists and approving further medical treatment. Services received outside of the HMO network are not covered, except in the case of emergency medical care. The chart below provides a high level overview of your medical plan options.

Features	Select HMO	Full HMO
Annual Deductible		
• Individual	None	None
• Family	None	None
Out of Pocket Maximum		
• Individual	\$1,500	\$1,500
• Family	\$3,000	\$3,000
Preventative Care	No Charge	No Charge
Primary Care Physician Visit	\$20	\$20
Specialist Visit	\$20 (referral from your PCP required)	\$20 (referral from your PCP required)
MDLIVE or Virtual Visits	\$20 (PCP or Specialist)	\$20 (PCP or Specialist)
Lab / X-Ray	No Charge	No Charge
Urgent Care	\$20	\$20
Emergency Room	\$100	\$100
Outpatient Surgery		
• Ambulatory Surgical Center	No Charge	No Charge
• Hospital	No Charge	No Charge
Inpatient Hospital	No Charge	No Charge
Prescription Drugs (Retail, per 30-day supply)		
• Annual Rx Deductible	None	None
• Generic	\$10	\$10
• Preferred Brand	\$15	\$15
• Non-Preferred Brand	\$60	\$60
• Specialty	20%	20%

Coinurance percentages and copay amounts shown represent what the member is responsible for paying To see a list of providers, visit www.mycigna.com

Make the Most of Your Benefits

- Seek care from in-network professionals only
- Take advantage of the 90-day prescription Home Delivery program (Generic = \$20; Preferred Brand = \$30; Non-Preferred Brand = \$120)

CLICK HERE to watch a video on Health Maintenance Organizations (HMO)

CLICK HERE to watch a video on PPO vs HMO

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Cigna Medical Open Access Plus (PPO) Plan



The Open Access Plus (PPO) plan give you the freedom to seek care from the provider of your choice; however, you will maximize your benefits and reduce your out of pocket costs if you choose a provider who participates in the Cigna network. The chart below provides a high level overview of your medical plan option.

Features	Open Access Plus (PPO)	
	In-Network	Out-of-Network
Annual Deductible		
• Individual	\$500	\$500
• Family	\$1,500	\$1,500
Annual Out-of-Pocket Maximum		
• Individual	\$4,000	\$10,500
• Family	\$8,000	\$21,000
Preventive Care	No Charge	40%*
Primary Care Physician Visit	\$35	40%*
Specialist Visit	\$45	40%*
MDLIVE or Virtual Visits	\$35 (MDLIVE or PCP) \$40 (Specialist Virtual Visit)	MDLIVE – Not Covered 40% (Primary Care / Specialist Visit)*
Lab / X-Ray	\$35 PCP Office / \$45 Specialist Office 20% at Independent / Outpatient Lab, after deductible	40%*
Urgent Care	\$35	40%*
Emergency Room	\$150 + 20%	\$150 + 20%
Outpatient Hospital		
• Outpatient Surgery	20%*	40%*
• Hospital	20%*	40%*
Inpatient Hospital	20%*	40%*
Prescription Drugs		
• Annual Rx Deductible	None	N/A
• Generic	\$10	Not Covered
• Preferred Brand	\$30	Not Covered
• Non-Preferred Brand	\$50	Not Covered
• Specialty	\$100 Retail / \$100 Home Delivery (30-day Supply)	Not Covered

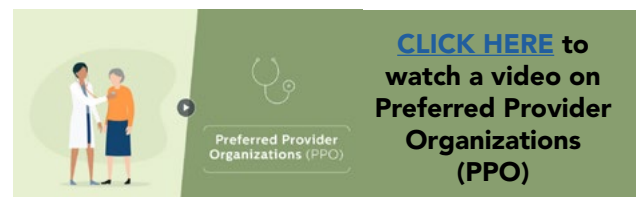
Coinsurance percentages and copay amounts shown represent what the member is responsible for paying.

* Benefits with an asterisk require that the deductible be met before the plan begins to pay.

To see a list of providers, visit www.mycigna.com

Make the Most of Your Benefits

- Use in-network providers
- Utilize your preventative services (vaccinations, screenings)
- Know and understand your costs up front



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Find a Doctor First, then Enroll



Is your doctor or hospital in your plan's Cigna network? Cigna's online directory makes it easy to find who (or what) you're looking for.

If you are not enrolled yet, follow the below instructions to find a doctor.

- **Step 1** - Go to [Cigna.com](https://www.cigna.com) and click on "Find a Doctor" from the blue menu bar at the top of the screen. Then, under "How are you covered?" select "Employer or School."
- **Step 2** - Enter an address, city, or zip code to change the geographic location for your search.
- **Step 3** - Select how you want to search for a provider (Doctor Type, Doctor Name, or Health Facilities and Group Practices). Enter a name, specialty or other search term and click "Search."
- **Step 4** - Click on "Continue as guest."
- **Step 5** - Answer any clarifying questions, and then verify where you live (as that will determine the networks available), click "Continue."
- **Step 6** - Select one of the plans offered by your employer during open enrollment.
 - Southern California
 - Southern California Select
 - Open Access Plus, Open Access Plus Tiered
- **Step 7** - Select a provider from the list. Click on "See all Medical Groups" to see which medical groups the provider is affiliated with or click on "Get PCP ID #."
- **Step 8** - Make note of the PCP ID # as you will need this when you enroll through Ease. PCP selection is only required if enrolling in an HMO.

If you're already a Cigna member, log in to [myCigna.com](https://mycigna.com) or the myCigna® app to search your current plan's network.

[myCigna.com](https://mycigna.com)

Once you are enrolled, you'll have access to [myCigna.com](https://mycigna.com) – your one-stop source for managing your health plan, anytime, just about any place. On [myCigna.com](https://mycigna.com), you can estimate your health care costs, manage and track claims, learn how to live a healthier life and more.

Questions? Call the Cigna Pre-enrollment Hotline at [888-806-5094](tel:888-806-5094).



Preventative Care Services



Get the most out of your coverage by taking advantage of preventative care coverage. Preventive care is a specific group of services recommended when you don't have any symptoms and haven't been diagnosed with a related health issue. It includes your periodic wellness exam (check-up) and specific tests, certain health screenings, and most immunizations. Most of these services typically can take place during the same visit. Your first step in a healthier direction starts with prevention, and good prevention starts early and continues throughout your entire life. Even if you feel fine, going to the doctor for health tests and checkups is part of living a healthy life. Health screenings check for problems early, before you feel signs of sickness. Finding problems early often gives you more care choices with better results.

With your medical plan, preventative care services are covered at no cost, even before you meet the plan's deductible.

You and your health care provider will decide what preventive services are right for you, based on your age, gender, personal health and history, and current health. Below is a partial list of preventative care services. For a complete list of preventive services, visit <https://www.cdc.gov/chronic-disease/prevention/preventive-care.html>

- Routine physical exam
- Well baby and childcare
- Immunizations
- Bone density tests
- Cholesterol screenings
- Mammograms
- Pap smears/pelvic exams
- Prostate test
- Lab procedures
- Screenings for HIV, HPV, and domestic violence
- Breastfeeding supplies
- Contraceptive drugs, devices, and sterilization
- Smoking cessation



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. Once you have a symptom or your health care provider diagnoses a health issue, additional tests are not considered preventive care. You may receive other medically appropriate services during a periodic wellness exam that are not considered preventive. 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, check you plan materials, talk with your provider, or call the number on the back of your ID card.

Prescription Plan Highlights



Prescription drug coverage provides a benefit that is important to your overall health. If you enroll in medical coverage, you will receive coverage for prescription drugs through Cigna.

The City offers prescription drug coverage through Cigna for employees enrolled in the Cigna HMO and OAP Plans. Members will receive a Cigna ID card that includes their prescription benefits when initially enrolled in the City's health plan or if the member changes their health plan or adds a new dependent. When you present your ID card at a participating pharmacy, you will be charged a copay based on the type of prescription you receive and your plan's benefits.

The Cigna 90 Now program makes it easier for you to fill your maintenance medications. These are the medications you take on a regular basis to treat an ongoing health condition like asthma, diabetes, high blood pressure or high cholesterol. With the Cigna 90 Now program, you have the choice of how and where you fill your prescriptions.

30-day or 90-day Supply (Retail Pharmacy)

If you choose to fill a 30-day supply, you can use any retail pharmacy in your plan's network. You have the option of switching to a 90-day supply at any time.

If you choose to fill a 90-day (or 3-month) supply, you can use select in-network retail pharmacies that are approved to fill 90-day prescriptions. You also have the option to use Express Scripts Pharmacy, Cigna's home delivery pharmacy and save money by getting 3 months of medication for 2 months' copays!

90-day Supply (Express Scripts Mail Order)

Home delivery is a convenient and cost-effective option when you're taking a medication on a regular basis. With just a few simple clicks of your mobile phone, tablet or computer, your important medications will be on their way to your door (or location of your choice). To learn more, go to [Cigna.com/homedelivery](https://www.cigna.com/homedelivery). To get started using home delivery, log into the myCigna App or [myCigna.com](https://www.mycigna.com). Click on the prescriptions tab and select My Medications from the dropdown menu. Then click the button next to your medication name to move your prescription(s) electronically.

- Ask your doctor for a 90-day prescription with refills
- Ask your doctor's office to send your prescription electronically to Express Scripts Home Delivery or an approved in-network retail pharmacy

Choose Your Pharmacy

There are thousands of retail pharmacies in your plan's network. They include local pharmacies, grocery stores, retail chains and wholesale warehouse stores. Every pharmacy in your plan's network can fill 30-day prescriptions, and a select number of pharmacies can fill 90-day prescriptions. Below are some of the retail pharmacies in your plan's network that can fill 90-day prescriptions. To see a full list, log in to the myCigna App or [myCigna.com](https://www.mycigna.com), or go to [Cigna.com/Rx90network](https://www.cigna.com/Rx90network).

- CVS (including Target)
- Walmart (including Sam's Club)
- Kroger (including Ralphs, Food 4 Less)
- Albertson's/Safeway



Know Your Prescriptions

A drug formulary is a list of prescription medications, both generic and brand-name, that are covered by your medical plan. The lists are created to ensure patients have access to the effective medications at the lowest possible cost. Formularies are typically divided into tiers based on the type of drug and its cost. These groupings range from least expensive to most expensive cost to you.

- **Tier 1** – Usually includes generic drugs and has the lowest copays.
- **Tier 2** – Includes preferred brand-name drugs and non-preferred generics, with higher copays than tier 1.
- **Tier 3** – Non-preferred brand-name drugs with higher copays.
- **Tier 4** – Often includes specialty drugs used to treat complex or rare conditions, with the highest out-of-pocket costs.

If a medication is not on the formulary, a patient may have to pay the full cost out-of-pocket or go through an exceptions (authorization) process to get it covered.

How can I check to see if my prescriptions are covered?

You can view Cigna’s Standard 4-Tier Prescription Drug List online through the myCigna App or [myCigna.com](https://www.mycigna.com).

1. Click on the “**Find Care & Costs**” Tab, then select “**Price a Medication**”, and type in the name of our medication, or
2. Go to www.Cigna.com/PDL
 - Scroll down and click on “Drug Lists for Employer Plans
 - Scroll down to the “**Cigna Standard Prescription Drug List**” section
 - Click on the ([4-Tier, all specialty medications covered on tier 4](#)) link.
3. Questions? Use the [myCigna.com](https://www.mycigna.com) chat Monday – Friday, 9:00 am to 8:00 pm EST or call the number on your Cigna ID Healthcare ID card 24/7/365.

The formulary will show which medications are covered, the coverage tier, and if the medication is subject to prior authorization, quantity limits, step therapy, or age requirements.





Omada Health – Healthy Habits Over Time

Whatever 'healthy' means to you, Omada helps you get there, at no additional cost to you.



What you get with Omada:

- A plan built for you
- Dedicated health coach and care team
- All the smart health devices you need

Do what works for you

- Find healthy habits and routines that work for you.

24/7 access to support

- Get all the tools you need to face any challenge head-on.

You decide what 'healthy' means

- Gain skills that allow you to break barriers to change.

There is no cost to eligible members and their adult dependents for the Cigna Diabetes Prevention Program in collaboration with Omada. Members are required to complete an eligibility screening in order to enroll and this requires they have a pre-diabetes diagnosis or risk factors for diabetes and/or heart disease. Members with an existing type 1 or 2 diabetes diagnosis are ineligible to apply.

Cigna does offer a well-being solution through Virgin Pulse that offers a full well-being experience for members as well. This is available at no cost.

Learn more at <https://go.omadahealth.com/omadaforcigna>.

Register on the [myCigna website](#) or app to receive additional information regarding Omada Health and the other benefits available to Cigna members.



Cigna Member Programs and Discounts



As a Cigna member, you have access to many other Healthy products and programs.

To get started go to <https://discoverhealthyrewards.sites.cigna.com/> and register at <https://my.cigna.com> to access all your benefits.

Active & Fit

One membership, thousands of ways to stay active and save money.

- \$28/mo standard fitness membership
- 12,200+ gyms
- 9,700+ on-demand videos
- Spouses eligible
- No long-term fees or long-term contracts
- Switch gyms anytime

To get started, <https://discoverhealthyrewards.sites.cigna.com>.

LASIK Eye Surgery Discounts

Access savings on LASIK just for being a Cigna member!

- Cigna members receive up to \$800 off LASIK.
- Members have access to more than 600 provider locations nationwide. Cigna members and their eligible dependents are entitled to significant and exclusive savings with credentialed providers.

Call [855-665-2020](tel:855-665-2020) or visit myCigna.com, select Wellness, then Prevention.

Amplifon Healthy Rewards

Cigna Healthy Rewards has teamed up with Amplifon to make high quality hearing care easy to access and affordable, including aftercare services.

- Risk-free trial
- Average savings of 64% off retail hearing aid prices
- Battery support - battery supply or charging station to keep you powered
- Warranty - 3 year coverage for loss, repairs, or damage.

For help with hearing care or to learn more, call or visit www.amplifonusa.com/healthyrewards or call [877-822-7095](tel:877-822-7095).



Well-being Solution Store

The wellness store offers over 400 items across 50 brands. That means there is something for every interest and every wellness goal, including:

- Fitness trackers
- Digital Scales
- Water bottles
- Bluetooth speakers
- Deep-tissue massages
- Beauty products and more

Scan the QR Code or go to www.mycigna.com > Wellness > More



Explore the online store today!

The store has something for everyone

Shop today to discover what's waiting for you!

The Wellness Store offers over 400 items across 50 brands. That means there's something for every interest and every wellness goal—and all at exclusive pricing just for our members. Shop a wide variety of health and wellness items like:

- Fitness trackers
- Digital scales
- Water bottles
- Bluetooth speakers
- Deep-tissue massagers
- Beauty products and more!



Scan the QR code and go to [myCigna](http://myCigna.com) > Wellness > More > Store.



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We offer dental benefits through Liberty Dental. With a dental HMO plan, you choose a primary dental provider to manage your care. There are no charges for most preventative services, no claim forms, and no deductibles. Reduced, pre-set charges apply to other services. The chart below provides a high level overview of your dental plan option.

Features	HMO LDP-400
Annual Deductible	None
Preventative Services (cleaning, x-rays)	\$0
Basic Services (fillings, oral surgery)	\$0 - \$105
Major Services (complete denture, maxillary)	\$85
Annual Maximum	None
Waiting Period	None
Orthodontia	\$1,775/Children, \$1,950/Adults

This is only a summary of the plan benefits. The complete Benefit Schedule and Evidence of Coverage must be consulted to determine exact copays, terms, limitations, and exclusions of coverage.

Why Dental Insurance

Did you know that a routine dental examination can detect symptoms of more than 125 diseases, including heart disease, diabetes, anemia and kidney disease?

We understand how important your health and well being are. Stay on track with a comprehensive dental plan.

To find a dentist:

1. Go to www.libertydentalplan.com/Ameritas.
2. From the Welcome Ameritas Members home page, select "California."
3. At the top of the Welcome Ameritas California Members page, click on "Find a Dentist."
4. Enter your search criteria (zip code, distance, specialist type) and click "Search."
5. A list of providers with the Office Number will appear. Select your dentist and make note of the office number.

Note: If you do not select a primary dentist when you first enroll, one will be assigned for you. You can change your dental office by calling the member services number on your dental ID card.

By registering for an account online, you can also view your dental benefits, check claims, and request or print ID cards

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Ameritas Fusion PPO Dental Plan



FUSION: THE ULTIMATE CHOICESM combines dental and eye care benefits in one easy-to-administer plan. This plan combines the annual maximum between the dental and eye care plans.

For the maximum:

- Each enrolled family member has up to \$2,500 per year to use toward any covered dental expense (in or out-of-network).
- Each enrolled family member can use up to \$100 towards any covered eye care expense.
- The total benefits paid between both dental and vision will not exceed \$2,500.
- You have the freedom to access services from any licensed dentist you choose, but accessing services from in-network providers saves you money.
- The Fusion PPO dental plan includes orthodontia coverage for adults and children.
- The Fusion PPO plan allows qualifying members to carryover part of their unused annual maximum

Ameritas Fusion PPO Dental		
Plan Benefit	In-Network	Out-of-Network
Network	Ameritas Classic Plus Network	None
Allowance	Discounted Fee	90th U & C
Deductible	\$50 per person Lifetime Waived for Type 1 Services	\$50 per person Lifetime Waived for Type 1 Services
Benefit Maximum	\$2,500 per member per calendar year	\$2,500 per member per calendar year
Type 1 • Exams • X-rays • Cleanings	100% (deductible waived)	100% (deductible waived)
Type 2 • Fillings • Endodontics • Periodontics • Extractions	100%	80%
Type 3 • Onlays • Crowns • Implants • Dentures	50%	50%
Orthodontia	\$2,000 per person Lifetime Max	\$2,000 per person Lifetime Max
• Adults	50%	50%
• Children	50%	50%
Dental Rewards	Included	Included
EyeCare	Up to \$100	Up to \$100

Dental Rewards		
This dental plan includes a valuable feature that allows qualifying plan members to carryover part of their unused annual maximum. A member earns dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan member doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But they can begin earning rewards again the very next year.		
Benefit Threshold	\$750	Dental benefits received for the year cannot exceed this amount.
Annual Carryover Amount	\$400	This Dental Rewards amount is added to the following year's maximum.
Maximum Carryover	\$1,200	This is the maximum possible accumulation for Dental Rewards.

Finding Providers

To find a provider, visit ameritas.com and select **FIND A PROVIDER**, then **DENTAL**. Enter your criteria to search by location or for a specific dentist or practice. California Residents: When prompted to select your network, choose the Ameritas Network found on your ID Card or contact Customer Connections at [800-487-5553](tel:800-487-5553).

Your provider network is Ameritas Classic Plus Network.

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We offer vision benefits through Ameritas. These plans offer you the freedom and flexibility to use the vision provider of your choice; however, you will maximize your benefits and reduce your out of pocket costs if you choose a provider who participates in the VSP or EyeMed networks. The chart below provides a high level overview of your vision plan option.

Ameritas Vision Plans	VSP - Focus		EyeMed – ViewPointe Plan H	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Network	Choice + Affiliates	N/A	Insight	N/A
Features				
Exam	Covered in full	Up to \$45	Covered in full	Up to \$35
Prescription Glasses				
• Single	Covered in full	Up to \$30	Covered in full	Up to \$25
• Bifocal	Covered in full	Up to \$50	Covered in full	Up to \$40
• Trifocal	Covered in full	Up to \$65	Covered in full	Up to \$55
• Lenticular	Covered in full	Up to \$100	20% Discount	No benefit
Frames				
• Allowance	\$150	Up to \$70	\$150	Up to \$75
Contact Lenses				
• Elective	Up to \$150	Up to \$120	Up to \$150	Up to \$120
• Medically Necessary	Covered in Full	Up to \$210	Covered in Full	Up to \$200
Frequency				
• Exams	Every 12 months		Every 12 months	
• Lens	Every 12 months		Every 12 months	
• Frames	Every 12 months (based on date of service)		Every 12 months (based on date of service)	

Both VSP and EyeMed offer additional savings and discounts. To Learn more, refer to the plan summaries available in Ease.

VSP Eye Care Plan Member Service

Focus eye care from Ameritas Group features the money-saving eye care network of VSP. Customer service is available to plan members through VSP’s well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

VSP Call Center: [800-877-7195](tel:800-877-7195)

- Service representative hours:
5 a.m. to 7 p.m. PST Monday through Friday,
6 a.m. to 2:30 p.m. PST Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at: ameritas.com

View plan benefit information at: vsp.com

EyeMed Eye Care Plan Member Service

ViewPointe eye care from Ameritas Group features the money-saving eye care network of EyeMed Vision Care. Customer service is available to plan members through EyeMed’s well-trained and helpful service representatives. Call or go online to locate the nearest EyeMed network provider, view plan benefit information and more.

EyeMed Customer Care Center: [866-289-0614](tel:866-289-0614)

- Service representative hours:
8 a.m. to 11 p.m. ET Monday through Saturday,
11 a.m. to 8 p.m. ET Sunday
- Interactive Voice Response available 24/7

Locate an EyeMed provider at: ameritas.com

View plan benefit information at: eyemedvisioncare.com

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Employee Costs - Dental and Vision



2026 Dental	Monthly Premium	Teamsters/P&AE		Police		Management, City Council, City Treasurer	
		City Portion	Employee Portion	City Portion	Employee Portion	City Portion	Employee Portion
Liberty Dental (DHMO/Prepaid)							
Emp. Only	\$15.04	\$15.04	\$0.00	\$15.04	\$0.00	\$15.04	\$0.00
Emp. +1 Dep	\$27.08	\$27.08	\$0.00	\$27.08	\$0.00	\$27.08	\$0.00
Emp. +2/More	\$39.12	\$39.12	\$0.00	\$39.12	\$0.00	\$39.12	\$0.00
Ameritas Dental (PPO)							
Emp. Only	\$59.38	\$59.38	\$0.00	\$59.38	\$0.00	\$59.38	\$0.00
Emp. +1 Dep	\$118.15	\$118.15	\$0.00	\$118.15	\$0.00	\$118.15	\$0.00
Emp. +2/More	\$208.44	\$208.44	\$0.00	\$208.44	\$0.00	\$208.44	\$0.00

2026 Vision	Monthly Premium	Teamsters/P&AE		Police		Management, City Council, City Treasurer	
		City Portion	Employee Portion	City Portion	Employee Portion	City Portion	Employee Portion
Ameritas - VSP Choice							
Emp. Only	\$10.52	\$0.00	\$10.52	\$0.00	\$10.52	\$10.52	\$0.00
Emp. +1 Dep	\$19.00	\$0.00	\$19.00	\$0.00	\$19.00	\$19.00	\$0.00
Emp. +2/More	\$27.36	\$0.00	\$27.36	\$0.00	\$27.36	\$27.36	\$0.00
Ameritas - EyeMed							
Emp. Only	\$8.60	\$0.00	\$8.60	\$0.00	\$8.60	\$8.60	\$0.00
Emp. +1 Dep	\$15.96	\$0.00	\$15.96	\$0.00	\$15.96	\$15.96	\$0.00
Emp. +2/More	\$23.36	\$0.00	\$23.36	\$0.00	\$23.36	\$23.36	\$0.00



We provide employees with life and accidental death and dismemberment (AD&D) insurance through Mutual of Omaha. The life insurance benefit is payable to the designated beneficiary upon the death of the insured. The AD&D insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot, or eye). If death occurs from an accident, both benefits would be payable. The chart below provides a high level overview of your life AD&D plan option.

Features	Life & AD&D
Life Benefit	Based upon Employee’s Memorandum of Understanding (MOU). For further details on this benefit, please contact Tyler Cashman at 310-318-0230 or tcashman@hermosabeach.gov .
AD&D Benefit	
Benefit Reduction	

Mutual of Omaha Short-Term Disability / Long-Term Disability Plan

We provide employees with disability insurance through Mutual of Omaha. If you become disabled and can’t work, no benefit becomes more important to your financial security than disability income protection. As an eligible employee, you are automatically covered by this plan at no cost to you.

Features	Short Term Disability / Long Term Disability
Percentage of Income Replaced	Based upon Employee’s Memorandum of Understanding (MOU). For further details on this benefit, please contact Tyler Cashman at 310-318-0230 or tcashman@hermosabeach.gov .
Maximum Benefit	
Benefit Duration	

Why a Disability Plan

Over 36 million Americans are classified as disabled. More than 50% of those disabled Americans are in their working years.

A disability plan provides income replacement if you experience a covered illness or injury. The coverage can help with everyday bills, such as mortgage or rent, that continue when you can’t work or expenses that health insurance won’t cover.



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Voluntary Term Life & AD&D



Life insurance is about more than just covering expenses. Depending on your circumstances, it could take your family years to recover from the loss of your income. Voluntary life insurance can provide the extra income your family may need to cover mortgage and rent payments, legal or medical fees, childcare, tuition, and any outstanding debts. Everyone's life insurance needs are different, depending on their family situation. That's why group life insurance through your employer can be an easy and affordable option.

Guarantee Issue is available to new hires. Amounts over the Guarantee Issue will require a health application/evidence of insurability. For late entrants, all amounts will require a health application/evidence of insurability.

Coverage Guidelines	Minimum	Guarantee Issue	Maximum
For You	\$10,000	5x annual salary, up to \$100,000	\$500,000, in increments of \$10,000, but no more than 5 times annual salary
Spouse	\$5,000	100% of employee's benefit, up to \$30,000	100% of employee's benefit, in increments of \$5,000, up to \$250,000
Children	\$2,000	100% of employee's benefit	100% of employee's benefit, in increments of \$1,000, up to \$10,000
AD&D Benefit	For you, your spouse and your dependent child(ren): The Principal Sum amount is equal to the amount of the life insurance benefit. AD&D coverage is available if you or your dependents are injured or die as a result of an accident, and the injury or death is independent of sickness and all other causes.		
Annual Benefit Amount Increase	If you enroll for even the minimum amount of coverage during your initial enrollment, you can increase your coverage at your next enrollment by up to \$10,000, provided the total amount of insurance does not exceed your maximum benefit amount. This feature allows you to secure additional life insurance protection in the event your needs change (ex. you get married or have a child). Amounts over the Guarantee Issue will require evidence of insurability (proof of good health).		





Mutual of Omaha – Additional Programs Available to All Employees

Employee Assistance Program

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral and mental health topics.

mutualofomaha.com/eap

or call: [800-316-2796](tel:800-316-2796)

Travel Assistance

Enjoy Your Trip – Mutual of Omaha Will Be There – 24/7

Travel Assistance can help you avoid unexpected bumps in the road anywhere in the world. For you, your spouse and dependent children on any single trip, up to 120 days in length, more than 100 miles from home.

Services available for business and personal travel.

For inquiries within the U.S. call toll free: [800-856-9947](tel:800-856-9947)

Outside the U.S. call collect: [312-935-3658](tel:312-935-3658) Worldwide Travel Assistance

Amplifon Hearing Care

Accessing Your Benefits is as Easy as ...

1. Call Amplifon at [888-534-1747](tel:888-534-1747) and a Patient Care Advocate will assist you in finding a hearing care provider near you.
2. Our advocate will explain the Amplifon process, request your mailing information and assist you in making an appointment with a hearing care provider.
3. Amplifon will send information to you and the hearing care provider. This will ensure your Amplifon discounts are activated.

Will Preparation Services

Creating a will is an important investment in your future. It specifies how you want your possessions to be distributed after you die. Whether you're single, married, have children or are a grandparent, your will should be tailored for your life situation.

Create your will at www.willprepservices.com and use the code MUTUALWILLS to register

Visit Ease for additional plan details.





LifeMatters® by Empathia – Provided to All Employees and their Families

Assistance with Life, Work and Wellbeing

When you or your family need useful ideas, helpful resources, or reliable professional care, LifeMatters is just a phone call away. Free, confidential services include:

Unlimited telephonic and six (6) scheduled counseling visits for:

- Stress, depression, and personal problems
- Balancing work and personal needs
- Family and relationship concerns
- Alcohol or drug dependency
- Workplace conflicts
- Any other issue of concern in your life

WorkLife Services:

- Financial consultation and resources to set up a budget, obtain and review credit report information, or assist with debt management and consolidation.
- Legal consultation with an attorney either over the phone or face-to-face for consumer law, traffic citations and fender benders, family law, or estate planning.

Online and assisted searches for:

- Child and elder care resources and guidance
- Adoption assistance
- Educational resources
- Personal security
- Online calculators for a variety of analytical questions and needs
- Home improvement
- Veterinarians, pet-sitting, and obedience training

The program's user-friendly, confidential services are available to you and your eligible dependents 24 hours a day, every day of the year.

Eligible members include significant others, eligible dependents, and household members.

Get in touch:

- **By phone:** [800-367-7474](tel:800-367-7474)
- **Online:** mylifematters.com; password CHB1



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What are Flexible Spending Accounts?

A flexible spending account (FSA) lets you save money by setting aside pre-tax dollars to pay for eligible expenses, including:

- **Healthcare FSA:** Medical, dental, and vision expenses (including copays, deductibles, glasses, and other eligible healthcare expenses not reimbursed by your health plans)
- **Dependent Care FSA:** Daycare expenses incurred by you, your spouse, or your eligible dependents.

What are the Advantages of Flexible Benefit Plans?

Employees can reduce taxable income and use the savings to pay for qualified expenses. Tax savings include federal income tax, and in most jurisdictions, state, and local income taxes. In addition, employees do not pay Social Security and Medicare tax on the amount excluded from income.

Putting money into an FSA decreases your taxable income, which means you will take home more money.

Healthcare FSA

With a Healthcare FSA, you can be reimbursed for medical expenses not covered or reimbursed by other insurance or plans like health savings accounts (HSAs) and health reimbursement arrangements (HRAs). All expenses must be qualified medical, vision, pharmacy or dental benefit expenses as defined by Section 213(d) of the IRS Code. All medical care expenses must be incurred during the plan year and the “use it or lose it” rule applies.

All of your Healthcare FSA dollars are available on the first day of the plan year. For example, if you choose to contribute \$1,200 to your FSA, your contributions will be deducted evenly across all of your paychecks for the year, but you have access to all \$1,200 on Day 1.

Carryover: Any balance remaining in your Health Care Reimbursement Account at the end of the Plan Year, up to \$660 (in 2026), will be carried forward and used to fund such benefits in any subsequent Plan Year. This carryover amount will not affect your ability to contribute the maximum amount (\$3,400 in 2026) in the subsequent Plan Year. Amounts above this carryover amount will be forfeited.

Funds may also be forfeited if you terminate your

employment.

Dependent Care FSA

Dependent Care FSAs allow you to accumulate pre-tax funds to reimburse for qualified childcare expenses or day care expenses for a disabled or elderly/disabled dependent. If married, employees generally must have a working spouse to qualify for a Dependent Care FSA. Dependent Care FSAs are also subject to the “use it or lose it” rule. Expenses must be incurred in the plan year. Funds do not roll over to the next plan year and may be forfeited if you leave the City.

Dependent Care dollars become available as you contribute to the plan through payroll deductions.

Contribution Limits

The IRS sets the maximum dollar amount you can elect to contribute to FSA Accounts.

- **Healthcare FSA:** The IRS limits the maximum contribution (\$3,400 in 2026).
- **Dependent Care FSA:** The IRS limits the maximum annual contribution to \$7,500 (\$3,750 if married and filing separately). Other IRS restrictions may apply.

Changing Your Elections

The elections you make during open enrollment will remain in effect for the plan year. You may only change your election after open enrollment if you experience a qualifying life event (see page 3). Contact Human Resources if you think you have had a qualifying event and want to make a change.

Sterling Services

For more information, go to www.sterlingadministration.com, call 800-617-4729, or email benefits@sterlingadministration.com.

- **Personal customer service on the phone and via email Monday – Friday**
- Online access to your account at www.sterlingadministration.com



Voluntary Benefits - Colonial



Voluntary benefits can help provide peace of mind by protecting your income and providing financial security for you and your family.

Life Insurance

Get the peace of mind and protection for your loved ones with life insurance. In addition to the life and accidental death and dismemberment insurance provided by the City, Colonial's voluntary life insurance can provide additional protection that can help your loved ones pay for ongoing living expenses, paying off debts, and financing future needs like paying for college or protecting retirement plans.

- Benefits are typically paid tax-free to the person you choose to receive your benefits.
- Life insurance policies are portable, so you can keep your coverage if you change jobs or retire.
- Guaranteed-issue coverage may be available for some plans, which means no medical questions or exams are required to be eligible for coverage.

Colonial Life works with Life Happens to help employees understand the value of life insurance. Find out how much life insurance you may need with the [Life Happens Insurance Calculator](#).

Accident Insurance

If you experience a covered accident or injury, accident insurance can provide a lump-sum benefit that is payable directly to you that can be used to help pay out-of-pocket expenses, such as doctor bills, copays, or emergency fees.

- A set amount is payable based on the injury you suffer and the treatment you receive.
- Benefits are payable directly to you (unless you specify otherwise) and be used as you see fit.
- Coverage is available for you, your spouse, and eligible dependent children.
- You do not need to answer medical questions or have a physical exam to get basic coverage.
- Accident insurance covers injuries that happen on the job or off the job, unlike workers' compensation, which only covers on-the-job injuries.

- Benefit payments are not reduced by any other insurance you may have with other companies.

You own the policy. If you leave your job, you can continue your coverage directly with Colonial Life.

Costs, eligibility and waiting periods before benefits are dispersed vary, so talk to with a Colonial Benefits Enrollment Counselor to learn more.

Critical Illness Insurance

A critical illness such as a heart attack, stroke, or major organ failure can impact anyone. When a critical illness strikes, major expenses often follow. Health insurance may cover some of your medical costs, but not everything. In addition to your day-to-day bills, you could incur costs for treatment and recovery such as:

- Deductibles and copays
- Expenses related to out-of-network treatment and additional medical procedures
- Travel, lodging and meals during treatment
- Rehabilitation and home health services
- Childcare

Talk to a Colonial Benefits Enrollment Counselor to find out which conditions are covered and how critical illness insurance can help you focus on getting better.

Additional coverage options are also available to help pay for health screenings, subsequent diagnoses, and cancer vaccines.



Hospital Indemnity Insurance

If you are admitted to the hospital for a covered accident or sickness, hospital indemnity insurance benefits can help you pay for hospital expenses that are not covered by your health insurance. Colonial Life's hospital indemnity insurance makes it easy to customize a policy and help prepare for unexpected expenses. After customizing a policy with a Colonial Benefits Enrollment Counselor, you can use your insurance to pay for day-to-day bills or out-of-pocket medical costs such as copays, co-insurance, and other expenses. All policies include:

- Benefits are payable directly to the policyholder (unless specified otherwise) that can be used for any purpose.
- Availability for you, your spouse, and your eligible dependent children.
- Clear benefit amounts so you know the exact amount that is payable for covered services.

You own the policy. If you leave your job, you can continue your coverage directly with Colonial Life.

Most plans even include an annual wellness benefit to help promote a healthy lifestyle.

Costs, exclusions, and limitations may vary. Talk to a Colonial Benefits Enrollment Counselor to learn more.



Cancer Insurance

Colonial Life's cancer insurance can help provide a financial safety net that can assist with covering cancer-related expenses that medical insurance does not cover, so you can focus on what matters most: recovery. If you are diagnosed with cancer, you may find that your medical insurance does not cover everything. In addition to day-to-day bills, you could incur costs for treatment such as:

- Deductibles and copays
- Out-of-network treatment
- Travel, lodging, and meals during treatment
- Childcare
- Home health services

If cancer affects your life, you should be able to focus on finding the best treatment and getting better – not on how to pay your bills. Coverage options are available for you, your spouse, and your eligible dependents.

- Benefits are payable directly to you unless you specify otherwise.
- Benefits are payable regardless of any insurance you have with other companies.
- Some policies can be taken with you, even if you change jobs.

Equally important, some plans also cover an annual cancer screening test to promote prevention and early diagnosis.

Optional riders may be available to provide even more financial protection during the initial diagnosis period and hospital stays.

Plans vary, so talk to a Colonial Benefits Enrollment Counselor to learn how cancer insurance can help provide financial protection for you and your family.

Deferred Compensation Plan



City of Hermosa Beach Deferred Compensation Plan for Public Employees



457 Governmental Plan and Trust Features and Highlights

A governmental 457(b) deferred compensation plan (457 Plan) is a retirement savings plan that allows eligible employees to supplement any existing retirement and pension benefits by saving and investing before-tax dollars through a voluntary salary contribution. Contributions and any earnings on contributions are tax-deferred until money is withdrawn. Distributions are subject to ordinary income tax.

Eligibility Requirements

To enroll in the Plan, employees must meet the following criteria:

- No age requirement
- Eligible employees may enroll each month.
- Please contact your Plan Administrator for information regarding excluded employees.

Contribution Limits

Deferred Salary

In 2026, the Deferred Salary amount is between 1% and 100% of your compensation or \$24,500.00, whichever is less. Special 457(b) catch-up contributions allow you for 3 years prior to normal retirement age to contribute the lesser of:

- Twice the annual limit, or
- The basic annual limit plus the amount of basic limit not used in prior years if not using age 50 or over catch-up contributions.

Participants turning age 50 or older in 2026 may contribute an additional \$8,000.00. Please note you cannot make age 50 and over catch-up contributions and special 457(b) catch-up contributions in the same year. Additional plan details are available in plan documents.

Roth Salary Deferral

The Roth option will give you the flexibility to designate all or part of your Governmental 457(b) elective deferrals as Roth contributions.

Roth contributions are made with after-tax dollars, as

opposed to the pre-tax dollars you contribute to a traditional Governmental 457(b). In other words, with the Roth option, you've already paid income taxes on money you contribute. With the traditional Governmental 457(b), your contribution is made on a pre-tax basis and you pay income taxes only when you take a distribution.

Enrollment

You may enroll by using the online enrollment option available at empowermyretirement.com:

1. Select Register.
2. Choose the I do not have a PIN tab.
3. Follow the prompts to create your username and password.
4. Call [866-816-4400](tel:866-816-4400) for enrollment help.

Top Reasons to Enroll

1. Starting early and making small increases in the amount you contribute could make a real difference when you retire.
2. You can reduce your taxable income.
3. A focus on monthly retirement income.
4. Review your finances in one place.
5. Contributions are automatic and controlled by you.

How do I get more information?

Visit the website at empowermyretirement.com or call the Voice Response System, toll free at [800-701-8255](tel:800-701-8255) for more information. The website provides information regarding your Plan, as well as financial education information, financial calculators and other tools to help you manage your account.

Dedicated Advisors

Your Empower Dedicated Retirement Plan Advisors:

Claudia Leao

claudia.leao@empower.com

C: [562-233-8524](tel:562-233-8524)

Shuster Advisory Group, LLC

JoAnn Parrino

O: [626-578-3429](tel:626-578-3429) C: [626-372-3299](tel:626-372-3299)

jparrino@sfgRPC.com

For more information, contact Human Resources.

ScholarShare529 Workplace Savings



Give the gift of knowledge, career skills and life-changing opportunities to a loved one—in the form of a tax-advantaged, benefits-oriented college savings account that can be used for a variety of qualified educational expenses.



ScholarShare529 is an industry leader with a 20-year track record of helping families save to cover future college costs. Benefits of the plan include:

- Tax favorable benefits (post-tax contributions and tax-free withdrawals for eligible expenses)
- Low fees
- Flexibility

How to Get Started

- Select your beneficiary(ies)
- Choose your investment portfolio
- Decide how much to save
- Fund your account

Want More Information?

Click on the links below for more information. Additional information is also available in Ease.

- [Register for a live and interactive webinar that fits your schedule](#)
- [Get started with a step-by-step guide](#)
- [View frequently asked questions and answers](#)
- [Learn about CalKIDS](#)
- [Schedule a consultation with your dedicated consultants](#)

City of Hermosa Beach Dedicated Consultants

Heath Polzer

TIAA 529 Consultant

[949-623-2916](tel:949-623-2916)

Heath.Polzer@tiaa.org

Julianna Gobin

TIAA 529 Consultant

[626-432-6314](tel:626-432-6314)

Julianna.Gobin@tiaa.org




How to Enroll



Self-enroll in your 2026 Benefits

You can select your 2026 benefits through the Ease online enrollment platform from the convenience of your work or home computer.

1. Log in at www.hermosabeach.ease.com using your username and password.
2. IF YOU FORGET YOUR PASSWORD: Click Forgot, enter your City of Hermosa Beach email address,
3. Click Submit.

 CITY OF
HERMOSA BEACH

Email or Username
example@email.com

Password [Forgot?](#)
.....

Login

[Español](#) · [简体中文](#) · [繁體中文](#)

4. When you log in, you will automatically be shown your dashboard.
5. Navigate to the top right and select “Start Enrollment” and select “Continue.”
6. Follow the prompts to select your benefits.
7. When you are finished enrolling, sign your forms, and print your enrollment summary.

You can access this portal all year long to reference your plan elections, view rates and detailed plan summaries.



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

The City of Hermosa Beach 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). The City of Hermosa Beach 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 contact Cigna member services using the number on your Cigna medical identification card.

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 Cigna member services using the number on your Cigna medical identification card.

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 Cigna member services using the number on your Cigna medical identification card.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Cigna. 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 Cigna member services using the number on your Cigna medical identification card.

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.



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.



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.



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 period¹ 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.

¹ <http://www.socialsecurity.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.



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:

Tyler Cashman
Human Resources Analyst
310-318-0230 or tcashman@hermosabeach.gov

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

The City of Hermosa Beach 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 Tyler Cashman at 310-318-0230 or tcashman@hermosabeach.gov.



Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about City of Hermosa Beach 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 City of Hermosa Beach	4. Employer Identification Number (EIN) 95-6000720	
5. Employer address 1315 Valley Dr.	6. Employer phone number 310-318-0230	
7. City Hermosa Beach	8. State CA	9. ZIP code 90254
10. Who can we contact about employee health coverage at this job? Tyler Cashman		
11. Phone number (if different from above)	12. Email address tcashman@hermosabeach.gov	

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.



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

City of Hermosa Beach has determined that the prescription drug coverage offered by the Cigna HMO and PPO plans 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 City of Hermosa Beach coverage will not be affected. If you keep this coverage and elect Medicare, the City of Hermosa Beach coverage will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current City of Hermosa Beach 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.



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.flmedicaidtprecovery.com/flmedicaidtprecovery.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: KIHIPPProgram@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: HSHIPPProgram@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://dhcftp.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 RItte 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://mywvhpp.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



Below is a listing of the telephone numbers you can call with questions about the plans available to you. You can also use the web site (if available) to access information from providers for the various plans.

Plan	Plan Number	Phone Number	Web Site/Email
Medical			
• Cigna Member Services	3346546	Refer to ID Card	www.Cigna.com www.myCigna.com
• Cigna Pre-enrollment Hotline		888-806-5094	
Dental			
• Liberty Dental HMO	010-62930	888-703-6999	www.libertydentalplan.com
• Ameritas Fusion PPO	010-62930	800-487-5553	www.ameritas.com
Vision			
• Ameritas - VSP	010-62930	800-877-7195	www.vsp.com
• Ameritas - EyeMed	010-62930	866-289-0614	www.eyemedvisioncare.com
Employee Assistance Program (EAP)			
• LifeMatters	City of Hermosa Beach	800-367-7474	www.mylifematters.com Password: CHB1
Basic Life / AD&D, Optional Life, Long Term Disability (LTD)			
• Mutual of Omaha	G000CF76	800-877-5176	www.mutualofomaha.com
Flexible Spending Accounts (FSA) and COBRA			
• Sterling	N/A	800-617-4729	customer.service@sterlingadministration.com
Colonial Voluntary Benefits			
• Brittany Lloyd	E4295929	925-759-6027	Brittany.Lloyd@coloniallifesales.com
457 Deferred Compensation Plan			
• Empower - Claudia Leao		562-233-8524	claudia.leao@empower.com empowermyretirement.com
• Shuster Advisory Group, LLC - JoAnn Parrino		O: 626-578-3429 C: 626-372-3299	jparrino@sfgRPC.com
College Savings Plan			
• ScholarShare529 - Heath Polzer		949-623-2916	Heath.Polzer@tiaa.org https://www.scholarshare529.com/
• ScholarShare529 - Julianna Gobin		626-432-6314	Julianna.Gobin@tiaa.org https://www.scholarshare529.com/
Benefits Consultant - Keenan & Associates			
• Kimberly Gleeson	N/A	949-940-1760 ext. 5175	kgleeson@keenand.com
• Andrea Estrin	N/A	949-940-1760 ext. 5133	aestrin@keenand.com
• Kelsey Marie White	N/A	949-940-1760 ext. 1123	kwhite@keenand.com



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).



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.

Health Reimbursement Arrangements (HRAs)

Unlike HSAs, only an employer may fund an HRA and the funds revert back to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs, and they may be paired with either high-deductible plans or traditional health plans.

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](#)

