2025

Employee Benefit Package

CITY OF
LONGMONT
COLORADO

Phone References and Group Numbers

If you have questions about plan coverage levels, specific claims, claim appeals or operations, please call the appropriate provider listed below.

Medical Coverage TTY711 unless specified otherwise

Kaiser Permanente	Group # 26902
New Member Connect Team	1-844-639-8657
Member Services Denver/Boulder	303-338-3800
Member Services Northern Colorado	1-844-201-5824
Member Services TTY	303-338-3820
Appointments and 24/7 Nurse Advice Line	303-338-4545
Pharmacy Services (refills)	303-340-5077
Health Line	1-800-332-7563
Health Line TTY	1-800-777-9059
Chiropractic & Complementary Medicine	1-844-800-0788
Hearing Aid Information	1-800-632-9700
PPO Dedicated Team	LongmontNavigators@kp.org
Behavioral Health Access – Denver/Boulder	303-471-7700
Behavioral Health – Northern Colorado	1-866-359-8299
Behavioral Health After-Hours	303-338-4545
NextCare Urgent Care – Longmont Only	303-772-0041
Dispatch Health Urgent Care Longmont & South	303-500-1518
UC Health Urgent Care – Longmont Only	720-745-8030

Additional Contacts listed in the **Care Options Guide** at: www.kp.org

Dental Coverage

Delta Dental Plan of Colorado
Group #11388
1-800-610-0201
www.deltadentalco.com

Vision Service Plan

Vision Service Plan (VSP)
Group #12-064211
1-800-877-7195
www.vsp.com

Employee Assistance Plan

Mines and Associates
800-873-7138
www.minesandassociates.com
Login: longmontcity

Spectrum Flexible Spending Account Program

Rocky Mountain Reserve, LLC. 888-722-1223
www.RockyMountainReserve.com

Retirement Plans

MissionSquare (formerly ICMA)

Police 401(a) Money Purchase Plan	Plan #109834
Fire 401(a) Money Purchase Plan	Plan #109835 457
Deferred Compensation Plan	Plan #300884
Retirement Health Savings (RHS) Plan	Plan #800077

1-800-669-7400
www.missionsq.org

Empower Retirement

General Employees MOPC 401(a) Plan #98748-01
1-800-701-8255
https://participant.empower-retirement.com/ui/login-ui/#/login

Basic Group Life, AD&D and Long-Term Disability Insurance

UNUM 1-866-679-3054
Policy #514327
www.unum.com

Employee Life and Survivor Income

New York Life 1-800-557-7975
Policy #FLX-961101
GBSClientService@NewYorkLife.com

Voluntary Supplemental Insurance

AFLAC http://www.aflac.com
Local Representative, Emma Crenshaw 913-961-9147
emma_crenshaw@us.afac.com

Pet Insurance

Nationwide Insurance
www.petinsurance.com/longmontcolorado

529 CollegeInvest **www.collegeinvest.org**

Fire and Police Pension Association of Colorado **1-800-332-3772**
Fax 303-771-7622
www.fppaco.org

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Introduction

The City of Longmont ("City") is pleased to provide eligible employees with a robust benefits package designed to meet your individual needs and preferences. These plans include a wide array of group insurance and retirement programs described in the booklet sections that follow. This booklet is updated annually and posted on *Inside Longmont* for your use each year.

Review this booklet carefully. It is our principal source for plan information. We should all become familiar with the terms, conditions and limitations of our plans so that we know how to use them when the need arises. Not knowing a plan's provisions could result in substantial unnecessary charges being paid by you.

Please note and understand the following:

- ***While the City intends to continue its benefit plans indefinitely, the City does reserve the right to amend or terminate the plans at any time. This right of amendment/ termination applies equally to active employees and retired employees alike.***

- ***In the event of a discrepancy between this booklet and the plan document for a specific benefit program, the respective plan document will govern. To review any of the plan documents, call the Compensation and Benefits Manager at 303-651-8606.***

- ***Enrollment for employee benefits in no way constitutes an employment contract, a guarantee of future employment or a guarantee of future benefit coverage.***

- ***Annual Health Care and Flexible Spending Account elections are irrevocable, unless you experience a qualifying family status change.***

- ***None of the retirement plans have a loan provision, and other access to funds is extremely limited. See the retirement plan sections later in this booklet for more information.***

If you require additional information about plan provisions and processes, call the respective benefit plan provider listed in the front of this booklet. We cannot speak for our providers, since they alone apply each plan's provisions. Keep copies of all your forms and claims submissions.

Plan Costs

Employee payroll-deducted contributions are made pre-tax and are based on your salary schedule, with three-quarter and half--time employees paying a proportionally higher premium. ***All premiums are subject to change.***

The City pays the full cost of these benefits: Single HMO, Basic Life, AD&D, Long-term Disability and the Employee Assistance Plan. In addition, the City pays administrative costs for COBRA and Flexible Spending Accounts.

The City shares with employees the cost of these benefits: Medical, Dental, Vision, Retirement and FPPA. Most employee contributions are deducted from each of your pay checks on a pre-tax basis.

Employees pay the full cost of these benefits: Supplemental Life and Survivor Income, contributions to Flexible Spending Accounts, contributions and fees to the 457 Deferred Compensation Plan, MOPC custodian fees and AFLAC premiums.

Benefits as a Percentage of Your Pay

The City is committed to assisting employees to provide for their financial security. This investment is shown clearly when we consider the percentage of our earnings that the City pays toward our benefit costs. On average, benefit costs paid by the City exceed **30%** of base pay.

Let's take a closer look. Assume a single full-time employee earning $60,000 per year with one year of service. In benefits the City pays over $24,000, bringing the total paid for this employee to more than $84,183.92 as we see here:

HMO Medical	$6,724.20
Dental and Vision	420.00
Life, AD&D, and LTD	395.40
Retirement (GERP+MOPC)	8,160.00
Retirement Health Savings	400.00
Vacation	2,769.23
Holidays	2,769.23
Sick Leave	2,769.23
Employee Assistance	28.68
Total	**$24,435.97**
or 40.72% of pay	

Electing Family HMO coverage increases the City's cost to **$39,901.83 or 66.5% of pay**.

As you can see, the City makes a substantial investment in helping each of us achieve financial security for ourselves and for our families.

Additional information is on our intranet site *Inside Longmont.* And be sure to check your e-mail regularly and the monthly publication "Employee Connection" for updates as well. These are our principal means of communication.

BENEFIT HIGHLIGHTS

Eligibility

Employees working in positions for which benefits are budgeted are eligible for benefit plan coverage, provided such eligible employees work a minimum of 1,040 hours per year. Enrollment in mandatory plans is automatic.

Also, under the terms of the Affordable Care Act *any* employee who works consistently 30 hours per week or more is eligible to enroll for *medical coverage only*. To maintain eligibility, such employees must continue to work consistently 30 hours per week or more each year between October 1 and September 30. Otherwise, coverage will end until the hours requirement is met again.

Eligible dependents under the medical, dental and vision plans include only your:

- Legal spouse, including Common Law and same sex *(a divorced spouse is not eligible and must be removed immediately* or you could be held responsible for unnecessary claims and premiums paid by the City);
- Dependent children to age 26, including your natural children, stepchildren, adopted children, children placed with you for adoption, and children for whom you obtain court-ordered legal guardianship.

No other dependents are eligible for coverage. ***Documentation is required*** for all dependent enrollments to verify dependent eligibility, e.g., marriage certificate with joint financial documents, tax return, birth certificate, adoption papers, legal guardianship papers, etc. Your application is complete only with the documents shown on pages 126-127. *The 31-day enrollment period is not extended for the receipt of this documentation.* **Keep copies of all your enrollment forms and supporting documents.**

Benefit eligible employees are eligible for retirement plan participation immediately upon hire. Enrollment is automatic, and participation in the plans is a mandatory condition of employment. More information is provided in the retirement plan section later in this booklet.

Enrollment and Effective Date of Coverage

Your voluntary enrollment for medical, dental and vision coverage must be completed **within 31-calendar days** of your date of hire; otherwise, you must wait until the next Open Enrollment period. *Enrollment is complete only when the required applications **AND** supporting dependent documentation are provided.*

Coverage becomes effective on the first day of the month coincident with or next following receipt in Human Resources of your completed enrollment forms **and** dependent documents, provided your forms **and** dependent documentation are received within your first 31-calendar days of service. Insurance enrollment is not retroactive. If you do not enroll during your **first 31 calendar days** of eligibility, you must wait until the next Open Enrollment period, or until you experience a "Special Enrollment" situation described in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Documentation of your special enrollment situation is required. Contact Human Resources for more information.

Newborns for medical only are enrolled automatically (but temporarily) for the first 31 calendar days of life. For permanent coverage, you must enroll your newborn through Human Resources within those first **31 calendar days following birth** or coverage will end. You must then wait until the next Open Enrollment and get coverage on your own and at your own cost. All required documentation must be submitted within this 31-day period. Until you obtain a birth certificate, you can submit a hospital confirmation of birth. ***Do not wait for Social Security Numbers.*** Dental and vision are effective on the first of the following month.

HIPAA Special Enrollment

If you decline 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 the City's plan if you or your dependents lose eligibility for that other coverage or if the employer providing that other coverage stops contributing toward your or your dependents' other coverage. However, you must request enrollment under the City's plan within 31 calendar days after your or your dependents' other coverage ends or within 31 calendar days after the employer stops contributing toward the other coverage.

In addition, if you gain a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 calendar days after the marriage, birth, adoption, or placement for adoption. Documentation is required. See Pages 129-130 for a list of required dependent documents.

Changing Elections during the Plan Year (January 1 – December 31)

Elections are irrevocable. Once you make your initial elections (or after the close of an Open Enrollment), your elections can be changed during the year **only** if you incur a qualifying change in family status or a HIPAA Special Enrollment Event. Except for birth of a child, changes are **effective the first of the month following** receipt of your completed application, including supporting documentation, provided the entire application is submitted complete within 31 calendar days of the event.

Qualifying status changes are changes to:

- your legal marital status: marriage, death of a spouse, divorce, separation or annulment (former spouses are not eligible and must be removed from coverage immediately to avoid charges for unnecessary payments):
- the number of your dependents: birth, death, adoption, placement for adoption or assumption of legal guardianship;
- employment status: start or termination of employment, strike or lockout, a commencement of or return from an unpaid leave of absence, or a change in work site that changes employment status of the employee, spouse or dependent or a change in employment status that results in an employee, spouse, or dependent becoming (or ceasing to be) eligible under a plan;
- your residence: a change in the place of residence or work of the employee, spouse, or dependent that affects your eligibility for coverage;
- dependent status: situations where a dependent satisfies or ceases to satisfy the rules for dependents, due to the attainment of age.

➢ *The Consistency Rule:* Changes in election may be made only when the status change affects eligibility for coverage and the election change corresponds with the change in eligibility. For example, if your dependent child reaches the maximum age and is no longer eligible for coverage, you can remove your child from coverage, but you cannot terminate your own coverage.

WHEN INSURANCE COVERAGE ENDS: your group insurance coverage ends on the last day of the month in which you are actively at work performing your regularly assigned job duties.

OPEN ENROLLMENT

Open Enrollment is held each year in late October/early November. During this time, you may change elections for the following year. However, once Open Enrollment closes, your elections cannot be changed without a qualifying change in family status; there is no added grace period until the end of the year. Elections become effective the following January 1-December 31.

QUESTIONS?

If you have questions about plan provisions or specific claims, you should call the appropriate provider directly at the phone number listed at the front of this booklet. These providers are responsible for administering the plans' provisions and will make all decisions regarding the payment of benefits.

We are not able to speak on behalf of any of our benefit providers.

If you have questions about eligibility or enrollment **only**, call Human Resources at 303-651-8606, 8607 or 8609.

SUMMARY OF BENEFIT CHANGES EFFECTIVE JANUARY 1, 2025

Medical Plans:

- ✓ **HMO** - Some of the plan design features of the HMO are changing. The biggest change is that the HMO now includes a small deductible. For most types of care, you will still be charged only a copayment (and please note that some of the copays are changing). For certain services, including inpatient hospital, outpatient surgery at a hospital, and diagnostic imaging, you will first be charged the full amount up to the $250 individual or $500 family deductible (in-network). After you've satisfied the deductible, you will then pay 10% of charges ("coinsurance") until all of your payments, including your copays, reach the out-of-pocket maximum for the year. If you reach your out-of-pocket maximum, you will pay nothing additional for covered services for the rest of the year.
- ✓ **Choice PPO** - We are offering a new plan option to improve access to non-Kaiser providers. Replacing the Triple Option plan is Kaiser's new Choice PPO. Under the PPO, you may see Kaiser providers or Kaiser's expanded network of non-Kaiser providers at an in-network cost share. The new network includes many of the providers and facilities that members have been requesting, including Longmont United Hospital. If you'd prefer to go out of network, the Choice PPO offers out-of-network coverage. Note, however, that when you go out-of-network, you may be subject to not only higher cost sharing but also the potential for "balance billing" when providers charge you above and beyond what they charge the plan.

Flexible Spending Account and Deferred Compensation

- ✓ Health Flexible Spending maximum for 2025 is $3,300 per year.
- ✓ Dependent Flexible Spending maximum for 2025 is $5,000 per year.
- ✓ Deferred compensation maximum for 2025 is $23,500 per year.

MEDICAL INSURANCE COVERAGE

The City of Longmont (City) offers a choice between two Kaiser Permanente (Kaiser) plan options: a traditional HMO and a new Choice PPO plan to improve access to non-Kaiser providers. Be sure to establish your on-line account at www.kp.org, where you can make appointments, check lab results, chat with a doctor – and other functions. Also review the online Kaiser's ***Care Options Guide*** for help in the use of appropriate medical resources. If you are new to Kaiser, call their *New Member Contact Team* at 844-639-8657.

The information provided here is only a summary and does not replace Kaiser's ***Evidence of Coverage*** (EOC) book. The EOC is the final governing document for the plan, and you are **strongly** encouraged to order your own copy of the EOC from Kaiser. If you do not receive your ID Card(s) from Kaiser within 30 days of enrolling, call Kaiser at 303-338-3800. ***Verify benefits directly with Kaiser.***

HMO vs Choice PPO

With an HMO you MUST use Kaiser providers and facilities, and most of your cost sharing is with fixed-dollar copayments. There are no benefits paid for services received at non-network facilities, except for emergency situations. Call the *24/7 Nurse Advice Line* at 303-338-4545 for assistance in obtaining the proper level of care.

The Choice PPO allows you a wider range of provider choice. You may see Kaiser providers or Kaiser's expanded network of non-Kaiser providers at an in-network cost share. The new network includes many of the providers and facilities that members have been requesting, including Longmont United Hospital. If you prefer to go out of network, the Choice PPO offers out-of-network coverage. However, when you go out-of-network, you may be subject to not only higher cost sharing but also the potential for "balance billing" when providers charge you above and beyond what they charge the plan.

Travel Medical Insurance - Whether you select HMO or Choice PPO, if you plan to travel overseas consider purchasing travel medical insurance from your travel agent or personal insurance agent. Our plans will cover **only emergency charges** incurred outside of the country, and getting such claims paid is extremely difficult. The cost of travel insurance depends on your age, length of trip and destination. Such a plan could save you time, effort and money.

EMERGENCY CARE

Emergency Care is expensive and should be used ONLY if you reasonably believe you or a dependent is in imminent danger of losing life or a limb. Emergency Care should ***NEVER*** be used for mere convenience. If possible, use a Kaiser Emergency facility, whose fees, on average, are $5,000 less than a non-Kaiser facility. Non-Kaiser Facilities like Longmont United, UC Health and free-standing Emergency Rooms (ER) are especially expensive and should be used only in dire circumstances.

Non-emergency situations should be treated by your primary care physician, urgent care (UC), on-line chat or through the **24/7 Nurse Advice Line: 303-338-4545.** The Nurse Advice Line can help you obtain the most appropriate level of care. Kaiser provides the following examples of Emergency and Urgent Care situations:

Emergency	Urgent
✓ Chest pain/pressure that radiates	✓ Colds, flu, headache, earache
✓ Severe shortness of breath	✓ Back pain, contusions, sprains
✓ Severe persistent bleeding	✓ Urinary tract infections
✓ Sudden severe abdominal pain	✓ Coughs, sore throat
✓ Sudden loss of consciousness	✓ Upper respiratory symptoms
✓ Major injuries and trauma	✓ Rashes and scrapes
✓ Psychiatric/behavioral emergency	✓ Minor injuries
✓ Active labor	✓ Minor allergic reactions

Urgent Care for a $50 copayment is now available at **Nextcare**, but only at the Longmont location: 2144 Main Street. Nextcare hours are Monday-Friday, 8am-8pm; and weekends, 9am-4pm. Phone: 303-772-0041, or www.nextcare.com.

UCHealth Urgent Care is also available at 2101 Main Street in Longmont only, Monday – Sunday, 8am-8pm. Phone: 720-754-8030. And **Dispatch Health** can bring urgent care to your home Monday-Sunday, 8am-10pm. Phone: 303-500-1518. Available presently at Longmont and South.

Chat Online at no cost to you is available daily from 8am-10pm. Sign into your Kaiser account and select the Chat icon to get started. A physician with access to your medical records will respond in a timely manner. You can even send pictures through chat.

Telephone Visits at no cost to you are enable you to schedule a call with your doctor Monday-Friday, form 8am-5:45pm. After hours physicians are available from 6pm-10pm. Call 303-338-4545 to schedule. Verify with your doctor the availability of phone visits.

EMPLOYEE PAYROLL DEDUCTED PRE-TAX CONTRIBUTIONS

On average, the City pays approximately 85% of the billed medical premium. The premiums you pay depend on: the option you select, the number of people you enroll, and your payroll schedule: full, half or three-quarter-time. Single full-time employees who elect HMO pay no premium. Premiums paid by half- and three-quarter-time employees are prorated based on scheduled hours. Premiums for three-quarter time employees who elect HMO single coverage are determined by rules set forth in the Affordable Care Act.

All employee premiums, including dental and vision, are deducted from your pay on a pre-tax basis, which reduces your taxable income for purposes of federal and state income tax. Pre-tax premium payment, or premium conversion, is part of the Spectrum Plan. Spectrum is governed

by Section 125 of the Internal Revenue Code, which imposes strict requirements that must be met to maintain continued compliance for tax-favored status. One example of these rules is the requirement that mid-year enrollment changes can be made ONLY if you experience a Qualifying Event or a HIPAA Special Enrollment Event. These events are discussed on pages 10-11 of this book.

The table below shows the current employee-paid per-pay-period premium amounts for the Kaiser HMO Plan:

Coverage Tier	**Full Time Employee**	**¾ Time Employee**	**½ Time Employee**
Employee Only	$0	$52.25	$129.31
Employee Plus 1 Dependent	$79.67	$191.52	$303.37
Employee Plus 2 or more Dependents	$181.04	$394.15	$607.77

The table below shows the current employee-paid per-pay-period premium amounts for the Kaiser Added Choice PPO Plan:

Coverage Tier	Full Time Employee	¾ Time Employee	½ Time Employee
Employee Only	$33.38	$108.50	$183.62
Employee Plus 1 Dependent	$102.84	$247.23	$391.61
Employee Plus 2 or more Dependents	$233.70	$508.80	$784.56

Under the Choice PPO Plan, be aware of preauthorization requirements. Despite the wider choice of providers under the Choice PPO, restrictions, exclusions and plan limitations do apply. Verify directly with Kaiser any information on benefits payable.

MEDICAL PLAN SUMMARY COMPARISON (Not Definitive)

The following pages provide a summary comparison of the Kaiser HMO and the Kaiser Choice PPO plans. **This summary is not a replacement for the EOC that will determine actual benefits payable under each plan.** To order a copy of the EOC and verify benefits for your plan, call Kaiser Member Services at 303-338- 3800. We cannot speak for any carrier.

Benefit	Kaiser HMO Plan	Kaiser Choice PPO Plan	
		In-Network	Out-of-Network
Annual Deductible			
Individual	$250	$250	$2,000
Family	$500	$500	$4,000
Out of Pocket Maximum			
Individual	$2,000	$2,000	$12,000
Family	$4,500	$4,000	$24,000
Includes cost of prescription drugs			
Individual Lifetime Maximum	Unlimited		
Covered Providers	Colorado Kaiser Permanente Medical Group	Kaiser Designated In-Network Providers	Out-of-Network Licensed Providers
Routine Office Visits			
Primary Care Providers	$20 copay per primary care office visit	$20 copay per primary care office visit	50% after deductible
Specialists	$40 copay per specialist care office visit; Other services: 10% after deductible	$40 copay per specialist care office visit; Other services: 10% after deductible	50% after deductible

Benefit	Kaiser HMO Plan	Kaiser Choice PPO Plan	
		In-Network	Out-of-Network
Preventive Care			
Children's Services	No charge (100% covered)	No charge (100% covered)	50% after deductible
Adult's Services	No charge (100% covered)	No charge (100% covered)	50% after deductible
Maternity			
Prenatal Care	10% after deductible	10% after deductible	50% after deductible
Delivery & Inpatient Well Baby Care	10% after deductible	10% after deductible	50% after deductible
Prescription Drugs			
Level of coverage and restrictions on prescriptions Formulary restrictions apply. Verify with Kaiser. Non-formulary medications not covered.	$15 copay for generic; $50 copay for preferred brand; $75 copay non-preferred drugs per prescription – up to 30-day supply; 30% coinsurance for specialty drugs up to a maximum of $300 per drug dispensed. Mail-order drugs available for up to a 90-day supply for 2x copayments	$15 copay for generic; $50 copay for preferred brand; $75 copay non-preferred drugs per prescription – up to 30-day supply; 30% coinsurance for specialty drugs up to a maximum of $300 per drug dispensed. Mail-order drugs available for up to a 90-day supply for 2x copayments	50% after deductible Mail-order drugs Not covered

Benefit	Kaiser HMO Plan	Kaiser Choice PPO Plan	
		In-Network	Out-of-Network
Inpatient Hospitalization	10% after deductible	10% after deductible	50% after deductible Precertification required
Outpatient Surgery	Ambulatory surgical center: No charge; Outpatient hospital: 10% after deductible	Ambulatory surgical center: No charge; Outpatient hospital: 10% after deductible	50% after deductible Precertification required
Diagnostics			
Routine Laboratory & X-ray	During office visit: No charge, deductible does not apply; Freestanding clinic and outpatient department of a hospital: 10% after deductible	During office visit: No charge, deductible does not apply; Freestanding clinic and outpatient department of a hospital: 10% after deductible	50% after deductible
Imaging (CT/PET scans, MRI's)	10% after deductible	10% after deductible	50% after deductible Precertification required

Benefit	Kaiser HMO Plan	Kaiser Choice PPO Plan	
		In-Network	Out-of-Network
Emergency Care for potentially life/limb threatening illness or injury	$500 / visit, deductible does not apply – waived if admitted.	$500 / visit, deductible does not apply – waived if admitted.	$500 / visit, deductible does not apply – waived if admitted.
Urgent Care	$50 / visit	$50 / visit	50% after deductible
Chiropractic (844-800-0788)	$20 copay/visit to 20 visits/year.	$20 copay/visit to 20 visits/year.	Not covered
Hearing Aid Allowance (800-632-9700)	Up to age 18: 1 aid / ear/ 60 months	Up to age 18: 1 aid / ear/ 60 months.	Not covered

Dental Insurance – Delta PPO *plus* Premier

Our voluntary Dental Plan is fully insured by Delta Dental Plan of Colorado. Participants may elect to receive care from any dental provider. However, you will receive higher benefits if you use a Delta network provider. Our program is called ***PPO plus Premier.***

Delta offers two provider networks that negotiate reimbursement rates with dentists: PPO and Premier. PPO dentists agree to a lower reimbursement rate than Premier dentists. **Therefore, you receive the HIGHEST benefit if you use a PPO dentist.** Also, when you use network dentists, you are not balance-billed or responsible for charges that exceed their contracted fees.

You can use any dentist you wish, but you will likely pay higher fees with a non-network dentist. And you may be liable to pay for charges that exceed the plan's covered amounts. *Verify all information about covered benefits directly with Delta.*

To see if your dentist is a Delta PPO or Premier Dentist, go to www.deltadentalco.com.

PREMIUMS

Both City contributions and employee-paid premiums go towards funding of the Dental Plan. The City pays 90% of the cost of employee-only coverage for a full-time employee. Part-time employees pay a portion of the cost of employee-only coverage based on scheduled hours. Employees pay the entire cost of dependent coverage. The following table shows the current employee-paid per-pay-period premiums for dental coverage.

Per-Pay Period Employee Paid Premiums for Dental Coverage			
Coverage Tier	**Full-Time Employees**	**Three-Quarter Time Employees**	**Half-Time Employees**
Employee Only	$1.68	$4.19	$8.38
Employee Plus 1 Dependent	$18.68	$21.19	$25.38
Employee Plus 2 or more Dependents	$54.84	$57.36	$61.55

Maximum Benefits
The maximum amount the Plan will pay out in any one calendar year for a covered participant is $1,500. Preventive services received from a PPO Dentist are not counted toward this maximum. A separate lifetime maximum of $1,500 is paid for orthodontia.

DEDUCTIBLES AND BENEFITS PAYABLE

The following table shows deductibles and the percentage of usual and customary charges payable under the Plan.

Deductibles	
Preventive/Diagnostic Services	None
Basic and Major Restorative Services per Participant	$25 per person paid once per calendar year
Percentage Payable	
Preventive/Diagnostic Services	100% of Eligible Expenses
Basic Restorative Services	80% of Eligible Expenses
Major Restorative Services	50% of Eligible Expenses

PREVENTIVE/DIAGNOSTIC SERVICES

The Plan pays for Preventive Services as indicated below (see Plan Document for details under each of the items shown here):

1. The following services are limited to twice every calendar year:
    - oral examinations;
    - prophylaxis (cleaning and scaling of teeth);
    - bite-wing x-rays; and
    - topical application of fluoride

2. Full-mouth series of x-rays, or panorex, provided that a period of at least 24 consecutive months has elapsed since the last such series of x-rays provided under the Plan.

3. Sealants covered up to age 15

BASIC RESTORATIVE SERVICES

The Plan pays for Basic Restorative Services as indicated below (see Plan Document for details under each of the items shown here):

1. Extractions and alveolectomy at time of tooth extraction;
2. Amalgam, silicate, acrylic and composite restorations;
3. Dental surgery
4. Diagnostic x-ray and laboratory procedures required in relation to dental surgery;
5. General anesthesia required in relation to dental surgery
6. Endodontic treatment;
7. Periodontic treatment;
8. Consultations required by the attending Dentist;
9. Relines and rebases to existing dentures (see Plan Document for restrictions);
10. Necessary treatment for relief of dental pain;
11. Space maintainers for missing primary teeth and habit- breaking appliances;
12. Repair or recementing of crowns, inlays, onlays, bridgework or dentures.

MAJOR RESTORATIVE SERVICES

The Plan pays for Major Restorative Services as indicated below (see Plan Document for details under each of the items shown here):

1. Provision of initial fixed bridge restorations
2. Provision of initial removable of partial or complete dentures
3. Replacement of existing removable partial or complete dentures or fixed bridge restorations
4. Provision of crowns, inlays, onlays and gold foil restorations
5. Certain oral surgical procedures
6. Orthodontic care for children and adults is covered at 50% of eligible charges to a lifetime benefit maximum of $1,500 per participant, **not** applied to the annual benefit maximum.
7. Dental implants

Important Notes:

Questions about coverage levels and benefits payable should be addressed to Delta Dental. The Plan information provided here is limited and does not include all information regarding any of the Plans. A complete description of the Delta Dental Plan is available at any time through the Human Resources Department.

Prescription Drugs are not covered by this dental plan.

It is your responsibility to read and understand the benefits of the Plans before accessing care. Any discrepancy between the information contained herein and the Plan Documents will be governed by the Plan Documents.

Delta will send you an Explanation of Benefits (EOB) specifying your exact payment responsibility. Try to wait for your EOB before making payment so you do not pay more than necessary.

Also, Delta has a pre-treatment estimate process for high-cost procedures so that you can approximate your payment responsibility before you have that procedure. Your Delta dentist will know how to use this valuable service. Be sure that Delta performs the estimate.

If your Delta dentist tries to have you pay for charges that exceed his/her contracted fee, contact Delta immediately. Balance billing by Delta providers is expressly prohibited.

VISION SERVICE PLAN (VSP)

VSP is for vision correction only. Medical conditions of the eye are not covered by VSP, but they should be treated under our medical plan. You may choose between VSP Plans that offer you and your dependents coverage for refractive exams-only or a VSP Plan that covers both exams and the purchase of eyeglasses or contact lenses. Benefits are provided **every 12 months** and not by calendar year. Verify directly with VSP any information on benefits payable.

Employees choosing to participate in the Vision Service Plan can use the services of a VSP member doctor or may choose to see a non-member doctor. The cost for employee-only exam-only coverage is paid for entirely by the City. Plan upgrades for materials and dependent coverage are paid entirely by you.

The following table shows the four different plans available and the benefits and cost per pay period to you for each:

AVAILABLE PLANS AND PREMIUMS

Vision Service Plans			
Plan	**Coverage**	**Benefits**	**Cost to You**
Plan A	Employee Only Coverage	Exam only once every twelve months	None
Plan B	Employee Only Coverage	Exam and materials once every twelve months	$4.62 per pay period
Plan C	Employee Plus Dependent(s) Coverage	Exam only once every twelve months	$1.66 per pay period
Plan D	Employee Plus Dependent(s) Coverage	Exam and materials once every twelve months	$13.08 per pay period

PLAN BENEFIT AMOUNTS

The following table shows the covered expenses (based upon your Plan selection) when services are provided by a VSP Doctor:

When Services are Provided by a VSP Doctor		
Benefit	Exam Only Coverage	Exam Plus Materials Coverage
Exam	Covered in full	Covered in full
VSP LightCare	Not available	Covered in full
Single Vision Lenses	Not available	Covered in full
Lined Bifocal Lenses	Not available	Covered in full
Lined Trifocal Lenses	Not available	Covered in full
Lenticular Lenses	Not available	Covered in full
Frame (wholesale allowance, see footnote #2 following the out-of-network benefits table)	Not available	Covered up to $220 (up to $220 for Featured Frames and up to $110 at Costco) Plus 20% off any extra out-of-pocket costs.
Contact Lenses (instead of a complete pair of prescription glasses, see footnote #3 following the out-of-network benefits table)	Not available	Up to $200. You also receive a 15% discount for the contact lens exam. After that discount, your payment for the exam will not exceed $60.

Standard progressive lenses are available for no additional copayment, but additional charges do apply for non-routine exams, such as contact lens exams and retinal scans.

Benefits are available for Diabetic eye care: glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Prescription drugs for medical conditions of the eye are NOT covered through VSP but may be covered by Kaiser – depending on the medication. Call Kaiser for details.

The following table shows the reimbursable amounts (based upon your Plan selection) when services **are not** provided by a VSP Doctor:

When Services are Provided by an Out-Of-Network Provider		
Benefit	**Exam Only Coverage**	**Exam Plus Materials Coverage**
Exam	Up to $50	Up to $50
VSP LightCare	Not available	Not available
Single Vision Lenses	Not available	Up to $50
Lined Bifocal Lenses	Not available	Up to $70
Lined Trifocal Lenses	Not available	Up to $100
Frame (based on retail cost)	Not available	Up to $70
Contact Lenses (instead of a complete pair of prescription glasses, see footnote #3 on the following page)	Not available	Up to $110

Progressive lenses are available for no additional copayment. Additional charges also apply to non-routine exams, such as contact lens exams and retinal scans.

A discount program is available through the Materials option for the purchase of TechShield, which protects against blue light emanating from electronic devices. Contact your VSP provider for details on this program.

Remember: benefits are provided every twelve months and not by calendar year. VSP uses a rolling twelve-month period to determine when you can receive benefits, and they are very precise with scheduling.

Visit www.vsp.com or call 800-877-7195 for more detailed information. Verify directly with VSP any benefits payable.

Footnotes

1. When an exam and/or materials are received from a VSP doctor, the patient will have no out-of-pocket expenses other than the copayment, unless optional items are selected. Optional items include, but are not limited to, oversize lenses (61 mm or larger), coated lenses, no-line multifocal lenses, treatments for cosmetic reasons or a frame that exceeds the plan allowance. VSP doctors offer valuable savings including a 20 percent discount on non-covered pairs of prescription glasses (lenses and frame). Services must be received within 12 months from the same VSP doctor who provided your last covered eye exam. You can also save 15 percent off the cost of your contact lens exam when you receive contact lens services from VSP. (This discount does not apply to contact lens materials).

2. Your VSP benefit provides guaranteed savings whether you choose a frame that is covered in full or one that exceeds the plan allowance. If you choose a frame valued at more than the plan's allowance, the difference you'll pay is based on VSP's low, discounted member pricing. Have your doctor help you choose the best frame for you based on your VSP coverage.

3. The allowance is in addition to the 15 percent discount on the contact lens exam. After the exam discount, your out-of- pocket payment for the exam will not exceed $60.00. The contact lens exam is a special exam for ensuring proper fit on your contacts and evaluating your vision with the contacts. Medically necessary contact lenses must be prescribed by your doctor (as required for certain medical conditions) and approved by VSP.

Additional Benefits through VSP

Laser Vision Correction: VSP's Laser VisionCare program is also available to those covered under any of the offered plans. It is designed to provide members with a discount on laser surgery when obtained through VSP contracted doctors, surgeons and laser centers. This program includes the two most common laser vision correction procedures, laser-assisted in-situ keratomileusis (LASIK) and photorefractive keratectomy (PRK). Call your VSP doctor to check if he or she is participating in the program. Doctors can also be located on VSP's Web site at www.vsp.com or by calling 888-354-4434.

TruHearing Discount program or hearing aids. Save up to $2,400 on a pair of hearing aids. In addition, you receive: three provider visits for fitting, adjustment and cleaning; 45-day money back guarantee; three-year manufacturer's warranty for repairs and one-time loss and damage; and 48 batteries per hearing aid. For more detailed information, call TruHearing at 877-396-7194. ***You and family members must mention VSP when you call.*** Available to any covered member of either VSP option.

TechShield from Sharper Image is now available through a discount program under the Exam+Materials Option to guard against blue light emanating from electronic devices. Contact your VSP Provider for details. Available to any covered member of either VSP option.

12-month Warranty on frames purchased from a VSP Provider. Also discounted lens replacement from VSP providers. Contact VSP or your VSP provider for details.

HOW TO USE YOUR VISION PLAN

Obtaining Services from a VSP Doctor
When you want to obtain vision care services, call a VSP doctor to make an appointment. To inquire about participating doctors, you may contact VSP at 800-877-7195 or on their Web site, www.vsp.com. **Make sure you identify yourself as a VSP member and be prepared to provide the covered employee's social security number**. The VSP doctor will contact VSP to verify your eligibility and plan coverage and will also obtain authorization for services and materials. If you are not currently eligible for services, the VSP doctor is responsible for communicating this to you. VSP will pay the doctor directly for covered services and materials.

Obtaining services from an out-of-network provider
Services and materials obtained from an out-of-network provider will be reimbursed up to amounts on the above schedule less any copayments. For out-of-network reimbursement, pay the entire bill when you receive services; send itemized receipts and VSP Reimbursement Request Form to VSP. Claims must be submitted to VSP within six months from your date of service.

Term Life and Accidental Death and Dismemberment Insurance

The City pays the full cost of basic term life and accidental death and dismemberment insurance for all regular benefit eligible employees through UNUM Life Insurance Company of America.

TERM LIFE INSURANCE

Eligibility and Coverage Levels
This Basic Term Life Plan is provided to all regular benefit eligible employees on the first of the month following 30 days of service.

The amount of coverage provided is equal to 1.5 X your annual base salary. Coverage amounts are rounded up to the next higher multiple of $1,000, if not already an exact multiple thereof.

The maximum coverage amount cannot exceed $250,000 regardless of annual base salary.

Coverage Reductions
The amount of coverage shown above will be reduced if you become insured at certain ages or have reached certain ages while insured.

There will be no further increases in your amount of life insurance.

If you have reached age 70, but not age 75, your amount of life insurance will be:

- 50% of the amount of life insurance you had prior to age 70; or
- 50% of the amount of life insurance shown above if you become insured on or after age 70 but before age 75.

If you have reached age 75, but not age 80, your amount of life insurance will be:

- 30% of the amount of life insurance you had prior to your first reduction; or
- 30% of the amount of life insurance shown above if you become insured on or after age 75 but before age 80.

If you have reached age 80 or more, your amount of life insurance will be:

- 20% of the amount of life insurance you had prior to your first reduction: or
- 20% of the amount of life insurance shown above if you become insured on or after age 80.

Accelerated Benefit
If you become terminally ill while you are insured by the plan, UNUM will pay you a portion of your life insurance benefit one time. The payment will be based on 100% of your life insurance amount.

Your right to exercise this option and to receive payment is subject to the following:

- you request this election, in writing, on a form acceptable to UNUM;
- you must be terminally ill at the time of payment of the Accelerated Benefit;
- your physician must certify, in writing, that you are terminally ill and your life expectancy has been reduced to less than 12 months; and
- the physician's certification must be deemed satisfactory to UNUM.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Benefits
When a serious accident occurs, it is a crisis for the individual and the family. Compensation for such an accident is provided as part of the life insurance benefit, at no additional cost to you.

When you are insured under the Basic Term Life Plan you are insured under this provision. If you are accidentally injured, and that injury is independent of sickness or other causes, the policy pays the benefit shown in the table below.

The Principal Amount is equal to your Basic Term Life Insurance death benefit amount so that the benefit for an accidental death is equal to three times your annual base pay, rounded up to the next $1,000.

AD&D Loss Table	
Loss	**Benefit**
Life	Full Principal Amount
Both hands, both feet or sight in both eyes	Full Principal Amount
One hand and one foot	Full Principal Amount
One hand or one foot and sight in one eye	Full Principal Amount
One hand or one foot	One Half Principal Amount
Sight in one eye	One Half Principal Amount

The maximum amount payable for any combination of Covered Losses is equal to the Full Principal Amount.

BENEFICIARY INFORMATION

As a new hire employee, you will be asked to complete a beneficiary designation sheet. Keep a copy of that sheet for your records. You may change your beneficiary information at any time by contacting the City's Human Resources Department.

Be sure to change your beneficiary if you experience a life change such as marriage, divorce or death of a beneficiary.

PORTABILITY/CONVERSION PRIVILEGE

You may convert your coverage under this group plan to an individual policy if you should leave the employment of the City.

Employees who are **not** disabled at the time of their separation from the City may apply for coverage continuation via a portability form. This coverage is offered at rates closest to those paid by the City during your tenure as a regular employee.

Employees who are disabled at the time of their separation from the City may apply for coverage continuation via a conversion form. Although conversion rates are considerably higher than portability rates, you cannot be denied coverage due to your disability.

In order to apply under either of these options, you must complete and send the necessary forms and first premium payment within **31 calendar days** of your termination date with the City.

Portability and conversion premiums are high, because no eligible applicant can be denied coverage due to a pre-existing illness.

If you are not disabled when you leave City employment and you are able to obtain life insurance elsewhere, it is possible that premiums for coverage obtained elsewhere will be lower than the portability/conversion premiums offered through the City's plan.

TOTAL DISABILITY AND LIFE INSURANCE CONTINUATION THROUGH WAIVER OF PREMIUM

If approved by UNUM an employee who becomes disabled while insured under this group plan may be able to continue coverage without payment of premiums. This provision is known as "Waiver of Premium" and is administered solely by UNUM.

The plan information provided here is limited and does not include all information regarding the plan. A summary plan description is available from Human Resources. In the event of a discrepancy between the information provided here and the plan document, the plan document will govern.

Long-term Disability Insurance

The City pays the entire cost of group Long Term Disability (LTD) Insurance offered through UNUM Life Insurance Company of America. Coverage is provided for all eligible employees. When a disability affects an employee, benefits payments are available.

With LTD Insurance, a portion of your income is protected if you are unable to work because of a disability.

BENEFITS AT A GLANCE

Waiting Period for Enrollment
You become covered as of the first of the month coinciding with or next following **30 days** of continuous active regular employment with the City.

Rehire
If your employment ends and you are rehired within 12 months, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

ELIMINATION PERIOD
The elimination period is the waiting period for benefits to begin after your disability occurs. This period is the later of:

- 90 days; or
- the date your accumulated sick leave payments end, if applicable.

Benefits begin the day after the elimination period is completed.

MONTHLY BENEFIT

The monthly benefit is equal to 60% of your monthly base earnings to a maximum benefit of $10,000 per month. ***Benefits are taxable as ordinary income****.*

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan. Benefit determinations are made solely by UNUM.

Maximum Period of Payment

Age at Time of Disability	Maximum Period of Payment
Less than age 60	To age 65, but not less than 5 years
Age 60	60 months
Age 61	48 months
Age 62	42 months
Age 63	36 months

Age 64	30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

OTHER FEATURES
(See the Plan Document for complete details)

- Continuity of Coverage
- Minimum Benefit
- Pre-Existing Condition/Limitation: 3/12
- Survivor Benefit
- Work Life Assistance Program

DEFINITION OF DISABILITY

You are disabled when UNUM determines that:

- You are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and
- you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury.

After 24 months of payments, you are disabled when UNUM determines that due to the same sickness or injury, you are unable to perform the duties of ***any*** gainful occupation for which you are reasonably fitted by education, training or experience.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

UNUM may require you to be examined by a physician, other medical practitioner or vocational expert of their choice. UNUM will pay for this examination. UNUM can require an examination as often as it is reasonable to do so. UNUM may also require you to be interviewed by an authorized UNUM Representative.

How Much Will You Receive if You Are Disabled?
UNUM will follow this process to figure your payment:

1. Multiply your monthly base earnings by 60%
2. The maximum monthly benefit is $10,000
3. Compare the answer from Item 1 with the maximum monthly benefit. The lesser of these two amounts is your gross disability payment.

What Are Your Monthly Earnings?
"Monthly Earnings" means your gross ***base*** monthly income from the City in effect just prior to your date of disability. It includes your total income before taxes. It is prior to any deductions made for pre-tax contributions to a qualified pension plan, qualified deferred compensation plan, Section 125 plan, or Flexible Spending Account. **It does not include** income received from commissions, bonuses, overtime pay, or any other extra compensation, or income received from sources other than the City.

What Are Indexed Monthly Earnings?
"Indexed monthly earnings" means your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10% or the current annual percentage increase in the Consumer Price Index. Your indexed monthly earnings may increase or remain the same but will never decrease.

What Are Disability Earnings?
"Disability earnings" means the earnings which you receive while you are disabled, plus the earnings you could receive if you were working to your maximum capacity.

How Much Will UNUM Pay if You Are Disabled and Working? UNUM will send you the monthly payment if you are disabled and your monthly disability earnings, if any, are less than 20% of your indexed monthly earnings, due to the same sickness or injury.

If you are disabled and your monthly disability earnings are 20% or more of your indexed monthly earnings, due to the same sickness or injury, UNUM will figure your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as disability earnings plus the gross disability payment does not exceed 100% of indexed monthly earnings.

1. Add your monthly disability earnings to your gross disability payment.
2. Compare the answer in Item 1 to your indexed monthly earnings.

If the answer from Item 1 is more than 100% of your indexed monthly earnings, UNUM will subtract the amount over 100% from your monthly payment.

After 12 months of payments, while working, you will receive payments based on the percentage of income you are losing due to your disability.

1. Subtract your disability earnings from your indexed monthly earnings.
2. Divide the answer in Item 1 by your indexed monthly earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer in Item 2. This is the amount UNUM will pay you each month.

During the first 24 months of disability payments, if your monthly disability earnings exceed 80% of your indexed monthly earnings, UNUM will stop sending you payments and your claim will end.

Beyond 24 months of disability payments, if your monthly disability earnings exceed the gross disability payment, UNUM will stop sending you payments and your claim will end.

UNUM may require you to send proof of your monthly disability earnings at least quarterly. UNUM will adjust your payment based on your quarterly disability earnings.

As part of your proof of disability earnings, UNUM can require that you send them appropriate financial records which UNUM believes are necessary to substantiate your income.

After the elimination period, if you are disabled for less than 1 month, UNUM will send you 1/30 of your payment for each day of disability.

WHAT ARE DEDUCTIBLE SOURCES OF INCOME?

UNUM will subtract from your gross disability payment the following deductible sources of income:

1. The amount that you receive or are entitled to receive under:
    - a workers' compensation law
    - an occupational disease law
    - any other act or law with similar intent
2. The amount that you receive or are entitled to receive as disability income payments under any:
    - state compulsory benefit act or law
    - other group insurance plan
    - governmental retirement system as a result of your job with the City

3. The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under:
    - the United States Social Security Act
    - the Canada Pension Plan
    - the Quebec Pension Plan
    - any similar plan or act
4. The amount that you receive as retirement payments or the amount your spouse and children receive as retirement payments because you are receiving retirement payments under:
    - the United States Social Security Act
    - the Canada Pension Plan
    - the Quebec Pension Plan
    - any similar plan or act
5. The amount that you:
    - receive as disability payments under a City retirement plan
    - voluntarily elect to receive as retirement payments under a City retirement plan
    - are eligible to receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined by the City's retirement plan

    Disability payments under a retirement plan will be those benefits which are paid due to disability and do not reduce the retirement benefit which would have been paid if the disability had not occurred.

    Retirement payments will be those benefits which are based on the City's contribution to the retirement plan.

    Disability benefits which reduce the retirement benefit under the plan will also be considered as a retirement benefit.

    Regardless of how the retirement funds from the retirement plan are distributed, UNUM will consider your and the City's contributions to be distributed simultaneously throughout your lifetime.

    Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. UNUM will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code including any future amendments which affect the definition.
6. The amount that you receive under Title 46, United States Code Section 688 (The Jones Act).
7. The amount that you receive under the mandatory portion of any "no fault" motor vehicle plan.

With the exception of retirement payments, UNUM will only subtract deductible sources of income which are payable as a result of the same disability.

UNUM will not reduce your payment by your Social Security retirement income if your disability begins after age 65 and you were already receiving Social Security retirement payments.

WHAT ARE NOT DEDUCTIBLE SOURCES OF INCOME?

UNUM will not subtract from your gross disability payment income you receive from, but not limited to, the following:

- 401(k) plans
- profit sharing plans
- thrift plans
- tax sheltered annuities
- stock ownership plans
- non-qualified plans of deferred compensation
- pension plans for partners
- military pension and disability income plans
- credit disability insurance
- franchise disability income plans
- a retirement plan from another employer
- individual retirement accounts (IRA)
- individual disability income plans
- salary continuation or accumulated sick leave plans

WHEN WILL PAYMENTS STOP?

UNUM will stop sending you payments and your claim will end on the earliest of the following:

- during the first 24 months of payments, when you are able to work in your regular occupation on a part-time basis but you choose not to;
- after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you choose not to;
- the end of the maximum period of payment;
- the date you are no longer disabled under the terms of the plan;
- the date you fail to submit proof of continuing disability;
- the date your disability earnings exceed the amount allowable under the plan;
- the date you die.

DISABILITIES WITH A LIMITED PAY PERIOD

Disabilities, due to sickness or injury, which are primarily based on self-reported symptoms, and disabilities due to mental illness have a limited pay period up to 24 months.

UNUM will continue to send you payments beyond the 24 months if you meet one or both of the following conditions:

1. If you are confined to a hospital or institution at the end of the 24-month period, UNUM will continue to send you payments during your confinement.

   If you are still disabled when you are discharged, UNUM will send you payments for a recovery period of up to 90 days.

   If you are confined again at any time during the recovery period and remain confined for at least 14 days in a row, UNUM will send payments during that additional confinement and for one additional recovery period up to 90 more days.
2. In addition to Item 1, if, after the 24-month period for which you have received payments, you continue to be disabled and subsequently become confined to a hospital or institution for at least 14 days in a row, UNUM will send payments during the length of the confinement.

UNUM will not apply the mental illness limitation to dementia if it is a result of:

- stroke;
- trauma;
- viral infection;
- Alzheimer's disease; or
- other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotropic drugs, or other similar methods of treatment.

WHAT DISABILITIES ARE NOT COVERED?

The plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- intentionally self-inflicted injuries while sane
- active participation in a riot
- loss of a professional license, occupational license or certification
- commission of a crime for which you have been convicted under state or federal law
- pre-existing condition

The plan will not cover disability due to war, declared or undeclared, or any act of war.

Important Note:

The Plan information provided here is limited and does not include all information regarding the Plan. A summary plan description is available from Human Resources. Any discrepancy between the information contained herein and the Plan Document will be governed by UNUM and the Plan Document. All benefit determinations are made solely by UNUM.

Employee Life and Survivor Income

(For all Regular Employees, except Uniformed Fire and Police)

PLAN HIGHLIGHTS

Employee Life and Survivor Income are replacement benefits and required as part of the City's January 1, 1980 withdrawal from Social Security. The benefits offered under this plan are the same level of benefits purchased through FICA when individuals work for an employer who has not withdrawn from Social Security.

PARTICIPATION

Participation and the purchase of these benefits is mandatory for all regular general employees. Participation is not required of or available to uniformed Fire and Police personnel due to their coverage under the FPPA Statewide Death and Disability Plan.

CONTRIBUTIONS TO THE PLAN

You pay the entire cost of this benefit which is 0.63% of your total gross earnings. This will show on your pay stub as an after-tax deduction under the heading of "Survivors Life".

WAITING PERIOD

You are covered under the plan as soon as you have completed 30 days of regular service with the City. If you are not actively at work on the day you would normally become covered, you will be covered on the day you return to active work.

EMPLOYEE LIFE BENEFITS

Death Benefit
If you die while insured for these benefits, $10,000 is payable to your beneficiary. You may change your beneficiary at any time by completing the necessary form available through the Human Resources Department.

After your death your beneficiary may:

(a) choose a mode of payment (lump sum or installments)
(b) name a person to receive any amount which would be paid to the beneficiary's estate.

Leaving Employment
If you leave employment with the City, your life coverage goes on for 31-days. During this time you may convert your life coverage to an individual life policy. Conversion forms will be made available to you at the time of your separation from the City.

Protection While Disabled
You might become totally disabled by injury or disease so that you are not able to engage in any work for which you are reasonably fitted by learning or experience. If this occurs while insured and before age sixty, your life protection may be extended. This protection will go on up to one year from the start of the disability, if you remain so disabled. Your protection may go on after that, if you complete the necessary conversion forms and give proof to the carrier that you are still so disabled. Proof must be given three months before each anniversary of the start of the disability. All necessary forms are available through the City's Human Resources Department. Total disability will be deemed to have ended if you do any work for pay or gain.

Your protection will end when you (a) cease to be totally disabled; or (b) fail to give required proof; or (c) fail to submit to a health exam. When your protection ends, you will have the same rights as those described above in "Leaving Employment," unless you become insured again as an active employee of the City.

If you die after you have converted your insurance, any amount paid under the Individual Policy will be deducted from the amount due under the Policy for active employees. Any premiums paid under the Individual Policy will be paid to your beneficiary on return of that policy.

SURVIVOR INCOME BENEFITS

Death Benefit
If you die while insured for these benefits and you are survived by a surviving spouse or eligible children, benefits are payable as follows.

Monthly Survivor Benefit
Your surviving lawful spouse OR child(ren) will be paid a monthly benefit equal to 30% of your latest monthly compensation to a maximum benefit of $1,000 per month. Benefits will begin as of the date you die and will be paid monthly thereafter. These payments will cease with the last payment before the date that the surviving spouse remarries, becomes age sixty-five or dies, whichever comes first.

If no spouse benefit is payable, the monthly benefit will be divided equally between all of your eligible children under age 19 (age 23 if a full-time student) if they were chiefly dependent on you for support and maintenance. A child may also be a stepchild living with you at the time of your death.

Protection after Termination

(a) If you are insured for Survivor Income Benefits on the day before you can convert your Employee Life coverage, then the amount of insurance you can convert will include the lump sum value of the survivor benefits on that day. This value will be based on your then attained age, the current interest rate and other sound actuarial assumptions, as determined by the carrier.

(b) If you die in the thirty-one day period in which you can convert your Employee Life coverage, the Survivor Income Benefits in force on the day before the thirty-one day period will be paid. The total amount of such payments will not be more than the difference between (1) the highest amount you could have converted as determined in (a) above, and (2) the highest amount you could have converted if there were no Survivor Income Benefits.

(c) If you die after your Employee Life coverage ends and while you are entitled to the benefit described in "Protection While Disabled" under the Employee Life section, the Survivor Income Benefits in force on the date your Life coverage ended will be paid. No benefits will be paid be paid under this part (c) if any benefits are payable under part (b) above.

GENERAL INFORMATION AND NOTES

Beneficiary
The beneficiary for your insurance for loss of life will be the person(s) named by you as shown on the records kept by the City. You may change your beneficiary at any time by completing the necessary forms and submitting them to the City's Human Resources Department. Keep copies of your designation forms.

If there is a part of your Employee Life coverage for which there is no named beneficiary living at your death, that part will be paid in a lump sum to the survivors the first surviving class of those that follow: your (a) spouse: (b) children; (c) parents; or (d) brothers and sisters. If none survives, that part will be paid in a lump sum to your estate.

If a minor has no legal guardian, that minor's share may be paid to the adult or adults who, in the carrier's opinion, have assumed the custody and support of the minor. Payment may be made at a rate up to $50 a month.

Notes:

(a) Changes in Survivor Income Benefit amounts become effective when your compensation changes. If you are not actively at work on that day, the change is postponed until you return to active work.
(b) Include only basic earning (not overtime, longevity pay, bonuses, etc.) in computing your compensation.

Important Note:

The Plan information provided here is limited and does not include all information regarding the Plan. A summary plan description of New York Life Employee Life and Survivor Income benefits is available at any time through the Human Resources Department. Any discrepancy between the information contained herein and the Plan Document will be governed by New York Life and the Plan Document. All benefit determinations are made solely by New York Life.

Fire and Police Pension Association (FPPA) Statewide Death & Disability Plan

(Uniformed Fire and Police Personnel Only)

INTRODUCTION AND BENEFITS

Statewide Death & Disability Plan benefits are state funded for police officers and firefighters hired prior to 01/01/97. The City pays the entire cost of coverage for individuals hired between 01/01/97 and 02/28/00, and splits the cost of coverage for individuals hired on or after 03/01/00. Premiums are set by FPPA.

Statewide Death & Disability Plan benefits provide 24-hour coverage, both on and off duty. Death & Disability Plan benefits are available for members not eligible for normal retirement under a defined benefit plan, or members who have not met 25 years of service and age 55 under a money purchase plan.

In the case of an on-duty death, benefits may be payable to the surviving spouse and/or dependent children of active members who were eligible to retire but were still working. See details under Survivor Benefits.

On-duty death and disability benefits are free from state and federal taxes.

The disability information listed here applies to benefits granted after October 1, 2002.

FPPA provides the police officers and firefighters of Colorado two types of disability, Occupational and Total.

Occupational Disability
Occupational Disability means a member is unable to perform his/her assigned duties due to a medical condition that is expected to last at least 1 year. Assigned duties are those specific tasks or jobs that a member is required to regularly perform.

Within the Occupational Disability category there are two sub- categories:

- Temporary Occupational Disability and
- Permanent Occupational Disability

The following table is a comparison of the benefits available for both Occupational Disability and Total Disability.

	Temporary Occupational Disability	**Permanent Occupational Disability**	**Total Disability**
Definition	An occupational disability for which there is prognosis for improvement or recovery through surgical treatment, counseling, medication, therapy or other means.	An occupational disability caused by a condition that is permanent or degenerative and for which there is no prognosis for improvement or recovery through surgical treatment, counseling, medication, therapy or other means.	Total Disability means the member is unable to perform any substantial gainful activity due to a physical or mental condition that may be expected to result in death or that has lasted or is expected to last at least 12 months.
Benefit Amount	40% of base salary	50% of base salary	70% of base salary
Benefit Start Date	Once granted, benefits are payable from the day following the member's last day on the employer's payroll.	Same	Same

	Temporary Occupational Disability	Permanent Occupational Disability	Total Disability
Duration Of Benefits	Maximum of 5 years. At the end of 5 years, the member either returns to department, upgrades to Permanent Occupational or Total Disability status, or benefits are discontinued. If the member is restored to active service with his/her former employer, FPPA will transfer from the D&D fund the contributions required to fund the money purchase plan or fund service credit under the defined benefit plan while the member was on Temporary Disability (up to 16%). If the mandatory contribution amount is above 16% the employer will make the additional contributions.	May be payable as long as the disability exists.	May be payable as long as the disability exists.
Periodic Re-examinations	Required. FPPA may also require treatment, counseling and therapy necessary to rehabilitate the applicant for return to work.	Generally not required.	Generally not required.

	Temporary Occupational Disability	Permanent Occupational Disability	Total Disability
Does Money Purchase or SRA offsets apply?	No. No offset or distribution	Yes, see section titled Disability & Survivor Benefit Offsets.	Yes, see section titled Disability & Survivor Benefit Offsets.
Upgrade in Disability Status	The member's benefit may be upgraded to permanent Occupational or Total Disability anytime within 5 years from his/her retirement date. Application must be filed no later than six months prior to the 5-year deadline	The member's benefit may be upgraded to permanent Occupational or Total Disability anytime within 5 years from his/her retirement date. Application must be filed no later than six months prior to the 5-year deadline	N/A
Does this benefit ever revert to a Normal Retirement?	Yes. If the member reaches age and service, including time on disability, under a defined benefit plan or 25 years and age 55 under a money purchase plan, FPPA will transfer from the D&D fund the contributions necessary for full service credits and the member will be granted a Normal Retirement in lieu of a continued disability. (If the money purchase plan's normal contribution rate is above 16% the employer will make the additional contributions.)	No	No

	Temporary Occupational Disability	Permanent Occupational Disability	Total Disability
What benefit payment options are available?	The member does not elect a payment option. Normal unreduced benefits are paid to the member. If he/she should die while receiving Temporary Disability, the Survivor Benefits explained later would apply.	Upon disability retirement, the disabled member elects one of the payment options listed below. This payment option determines what is payable to a beneficiary.	Upon disability retirement, the disabled member elects one of the payment options listed below. This payment option determines what is payable to a beneficiary.
Cost of Living Adjustments (COLA)	A COLA of up to 3% may be granted by the FPPA Board annually. The COLA is effective October 1. COLAs may begin after receiving retirement benefits for at least 12 months prior to October 1.	A COLA of up to 3% may be granted by the FPPA Board annually. The COLA is effective October 1. COLAs may begin after receiving retirement benefits for at least 12 months prior to October 1.	A COLA of up to 3% may be granted by the FPPA Board annually. The COLA is effective October 1. COLAs may begin after receiving retirement benefits for at least 12 months prior to October 1.

PAYOUT OPTIONS

The payout options listed below apply to Permanent Occupational Disability and Total Disability only. The corresponding benefit amounts shown earlier are used to calculate these payout options.

Normal Option
The disability retiree receives an unreduced benefit amount for life. Upon the retiree's death, the benefit is discontinued.

In addition to the Normal Option, the following options provide different levels of post-retirement survivor benefits for a reduced benefit amount. The amount of the reduction is based on the age of a member and the age of his/her designated beneficiary.

Option 1
The disability retiree receives a reduced disability benefit for life. Upon the retiree's death, the same reduced disability benefit is paid to the beneficiary for life.

Option 2
The disability retiree receives a reduced disability benefit for life. Upon the retiree's death, one-half of the retiree's reduced benefit is paid to the beneficiary for life.

Option 3
The disability retiree receives a reduced disability benefit for life. Upon the retiree's death, the same reduced benefit is paid to the surviving spouse for life, until the death of any incapacitated child, or until the youngest child reaches age 23, whichever is later.

DISABILITY & SURVIVOR BENEFIT OFFSETS

The benefit offsets listed here apply to those receiving Permanent Occupational Disability, Total Disability or Survivor Benefits.

The offsets are made to equalize the payment of death and disability benefits between the defined benefit and money purchase plans.

Money Purchase Plan
The 401(a) money purchase funds available to the member or survivor at the time disability or survivor benefits are awarded are used as an offset. The money purchase offset is calculated based on the member's age and account balance at the time of disability retirement or the survivor's age and member's account balance at the time of the member's death. Contributions made to the money purchase plan above 16% are not offset.

Earned Income
Due to recent legislative changes, there will no longer be an offset for earned income. A verification process will still be in place to confirm eligibility. Please see Verification of Eligibility below.

Defined Benefit from a Local Pension Plan
If a member is eligible to receive a defined benefit from a local pension plan, disability or survivor benefits will be reduced by the amount of the defined benefit.

Other Income and Investments
Spousal income, IRAs, insurance benefits, legal awards, deferred compensation accounts, and other investment incomes are not subject to any offset.

OTHER PROCEDURES

Verification of Eligibility

FPPA is required by law to monitor certain benefit eligibility requirements. Periodically, disability/survivor benefit recipients may receive a *Verification of Eligibility Affidavit* form to complete and return to FPPA. Certain supporting documents, such as tax returns may also be required. It is important that the *Verification of Eligibility Affidavit* and any required documentation must be returned to FPPA in order to avoid suspension of benefits.

Military Leave

A member on military leave continues to be covered by the Statewide Death and Disability Plan (up to a maximum of two years) upon payment of the required Statewide Death and Disability contribution by the employer. Any benefits payable under the Statewide Death and Disability Plan shall be offset by any death or disability benefits received from the military.

SURVIVOR BENEFITS

An active member's spouse and/or dependent children are eligible to receive survivor benefits from FPPA. The death of the member does not have to be duty related to qualify for benefits.

The benefits listed below are reduced by any applicable SRA or money purchase offset. Benefits may be increased by an annual cost-of-living-adjustment (COLA) of up to 3% effective October 1st. COLAs may begin after receiving retirement benefits for at least 12 calendar months prior to October 1.

	Survivor Benefits On-Duty Deaths	**Survivor Benefits Off-Duty Deaths**
Basic Benefit Amount (Before offsets are calculated)	Spouse only. 70% of base salary Spouse & dependent child(ren) living in the member's household. 70% of base salary No spouse. Dependent children living in the member's household. 70% of base salary No spouse. Dependent children **not** living in the member's household. 40% of base salary for the first child 15% for each additional child, not to exceed 70% total benefit	Spouse only. 40% of base salary Spouse and one dependent child. 40% of base salary Spouse and two or more dependent children. 50% of base salary No spouse. One or two dependent child(ren). 40% of base salary No spouse. Three or more dependent children. 50% of base salary
Retirement Eligibility	If your death occurs after you are eligible for normal retirement under a defined benefit plan or 25 years of service and age 55 under a money purchase plan, the survivor benefit paid to the surviving spouse and/or dependent children is the difference between 70% of base salary and the survivor benefit payable from the member's normal retirement plan.	If your death occurs after you are eligible for normal retirement under a defined benefit plan or 25 years of service and age 55 under a money purchase plan, the survivor receives the benefits payable under the member's normal retirement plan. No benefit is paid from the Statewide Death and Disability Plan.
Duration of Benefits	Survivor benefits to a spouse are payable for life. Benefits for dependent children are payable until the child marries, or reaches age 19 or if enrolled in school, age 23. Benefits may be extended for an incapacitated child.	Same

TAXABILITY OF BENEFITS

On-Duty Disability Benefit
On-duty disability benefits are free from state and federal income taxes in the event that a member's disability is determined by the FPPA Board to have occurred while on-duty or as a result of an occupational disease.

On-Duty Survivor Benefits
On-duty survivor benefits are free from state and federal income taxes in the event that a member's disability is determined by the FPPA Board to have occurred while on-duty or as a result of an occupational disease.

Money Purchase Plans
Members covered under either the Statewide Money Purchase Plan, or the Money Purchase Component of the Statewide Sybrid Plan and having been granted an on-duty disability receive his/her money purchase distribution tax-free.

Members of non-affiliated local money purchase plans should contact their local pension board and plan record keeper regarding the taxability of their money purchase pension plan assets.

Statewide Defined Benefit Plan – Separate Retirement Account (SRA)

Members having an SRA account and having been granted an on- duty disability shall receive his/her SRA distribution tax-free.

Important Note:

Every effort has been made to provide the above information as accurately as possible. However, all FPPA plan provisions are governed by the FPPA and their plan documents currently in place. Individuals who are interested in any of the benefits listed above or who have questions regarding these benefits should contact the FPPA directly at (800) 332-3772 or at www.FPPAco.org.

Voluntary Supplemental Insurance - AFLAC

INTRODUCTION TO SUPPLEMENTAL INSURANCE

Coverage under any of the AFLAC plans is supplemental and pays regardless of any other insurance. The benefits are paid directly to you unless you assign them elsewhere. You may, therefore, spend them as you see fit.

Enrollment is available during your initial 31-day enrollment period or during Open Enrollment only. Coverage changes may be made during Open Enrollment.
The City offers these supplemental insurance plans, presented by American Family Life

Assurance Company of Columbus (AFLAC). These plans are offered on a voluntary basis with the employee paying the entire cost of the premium. Depending on the plan, premiums may be withheld from your paycheck on a pre-tax or after-tax basis.

HIGHLIGHTS OF THE PLANS

- All Benefits are Paid Directly to You
- Additional Personal Financial Protection on and off of the job
- Premiums May Qualify for Pre-tax
- Guaranteed Renewable for Life
- Cash Incentives are Paid to You for Certain Routine Wellness Tests
- Payroll Rates Will Continue if You Ever Leave Employment With the City

OFFERER PLANS

- Personal Cancer Protector Plan
- Personal Hospital Intensive Care Protection
- Personal Accident Expense
- Personal Short-Term Disability
- Term Life Coverage
- Personal Long-Term Care Protection

BENEFITS PAYABLE

The following is a brief listing of the benefits payable under each of the available plans. There are many options to choose from and to tailor make your plan. To determine rates and to request additional information pm benefits and plan provisions, contact the City's AFLAC Associate, Emma Crenshaw, by phone at 913-961-9147 or by email at emma_crenshaw@us.afac.com.

Personal Cancer Protector Plan

- Hospital Confinement
- Radiation and Chemotherapy
- Experimental Treatment
- Anti-Nausea
- Nursing Services
- Surgical/Anesthesia
- Skin Cancer Surgery
- Prosthesis
- Outpatient Blood and Plasma
- In-Hospital Blood and Plasma
- Second Surgical Opinion
- National Cancer Institute Evaluation/Consultation
- Ambulance
- Transportation
- Lodging
- Bone Marrow Transplantation
- Stem Cell Transplantation Benefit
- Extended Care Facility
- Hospice
- Home Health Care
- Cancer Screening Wellness Benefit

Personal Hospital Intensive Care Protection

- Daily Hospital Intensive Care Unit
- Daily Sub-Acute Intensive Care Unit
- Human Organ Transplant
- Ambulance

Personal Accident Expense

- Accident Emergency Treatment
- Ambulance Benefit
- Accident Follow-up Treatment
- Blood and Plasma
- Initial Accident Hospitalization
- Accident Hospital Confinement
- Intensive Care Confinement
- Transportation
- Accident-Specific Sum Injuries
- Family Lodging
- Physical Therapy
- Prosthesis Benefit and Appliance
- Accidental-Death and Dismemberment
- Wellness

Personal Short-Term Disability

- An income protection plan that allows you to choose from among various options for benefit and elimination (waiting) periods.

Personal Long-Term Care

- First-Occurrence Benefit
- Nursing Home Daily Benefit
- Waiver of Premium Benefit
- Assisted-Living Benefit
- Home Care Benefit

Term Life Coverage

Important Note on AFLAC:
You must enroll within 31 calendar days of your hire date or during the City's annual open enrollment period. Mid-year changes are not permitted, and qualifying events do not apply. Mr. Ruff will assist you with premium amounts for the coverage that you select. Any questions about AFLAC coverage or process should be directed only to AFLAC and not to City staff.

Nationwide Pet Insurance

For information, go to: www.petinsurance.com/longmontcolorado

CollegeInvest 529 College Saving Plan

For information, go to: www.collegeinvest.org

Spectrum Plan – Before Tax Options

Most of us have health care expenses and premiums that we pay for out of our own pocket. In addition, many of us have unique needs when it comes to caring for our dependents. To assist you and your family in planning and paying for such expenses, the City offers the Spectrum Plan. However, enrollment is irrevocable without a qualifying family status change.

BEFORE-TAX PREMIUM PAYMENT

For most people, the Spectrum Plan increases your spendable income and lowers your taxes by allowing you to use pre-tax dollars to pay for medical, dental, vision and some supplemental insurance premiums with pre-tax dollars. This is called premium conversion.

FLEXIBLE SPENDING ACCOUNTS

By establishing a Medical Expense and/or a Dependent Care Flexible Spending Account, you are able to use pre-tax dollars to pay for eligible expenses. Consequently, you are able to reduce taxes and increase your spendable income. *Eligible expenses are incurred only when you are actually enrolled in the plan, which occurs on the first day of the month following the timely receipt of your enrollment application.*

Enrollment

New employees have 31 calendar days from their hire date to enroll in the plan. All other employees may enroll during the open enrollment period held each October/November for the coming plan year, or within 31 calendar days of a qualifying family event.

Participation End Date: you may incur claims only through your last day of employment, but you have another 90 days to file claims.

HEALTH CARE ACCOUNTS

Your health care flexible spending account may be established to reimburse you for health care expenses not covered by group medical and dental plans. The maximum amount that you can contribute to your health care flexible spending account is $3,300.00 per plan year ($126.92 per-pay-period based on 26 pay periods). Expenses may be for you or any person who would qualify as a dependent *whether or not* they are covered under the City's medical, dental or vision plans.

Eligible Medical Expenses

Expenses that are eligible for pre-tax payments are those expenses you incur for "medical care" (as defined in IRS Code Section 213.) See also IRS Publication 502 at www.irs.gov.

"Medical care" includes, but is not limited to, the following:

- Deductible and coinsurance amounts not paid by any medical, dental or vision insurance;
- Vision care expenses, including exams, lenses, frames and contacts, not covered under the Vision Service Plan that you selected or reimbursable under any other form of coverage;
- Medical, dental or vision expenses that exceed, or are not covered by the limits of your medical, dental and vision coverage;
- Prescription drug co-pay and co-insurance amounts not reimbursable under any coverage that you have;

Eligible expenses for your dependents may be reimbursed through this account even if they are not enrolled in either of the medical plans or the dental plan offered by the City. Premiums paid to and expenses paid by another insurance plan are not eligible for reimbursement through your health care spending account. You may be reimbursed your entire annual contribution amount before all of your contributions have been made.

DEPENDENT CARE ACCOUNTS

A dependent care account is available to both married and single employees. If you are married, the tax laws require, unless special circumstances exist, that both of you must be working in order to use your account. Reimbursement is made only from contributions that have actually been made to the plan.

You may set aside a maximum of $2,500 for a person filing an individual tax return or $5,000 per year for a married person filing a joint tax return. If you are married and file a joint tax return, the maximum deposit is the lesser of either your earned income or your spouse's (to a maximum of $5,000). See also IRS Publication 503 at www.irs.gov.

Eligible Dependent(s) and Eligible Dependent Care Expenses
To qualify for reimbursement:

- The dependent child (or children) must be 12 years of age or younger
- Dependents 13 years of age and older must be totally disabled and spend at least 8 hours each day in your home

Eligible Dependent(s) and Eligible Dependent Care Expenses
To qualify for reimbursement: (Continued)

- The dependent care services can be provided either inside or outside your home
- If the services are provided by a day care facility that cares for more than five children at one time, it has to be a state- licensed day care center

Any dependent or child-care costs that you pay to the following in order for you to work qualify for reimbursement:

- A qualified day care center, nursery school, babysitter or nurse
- A maid or cook – if part of the services are provided to a person who qualified for dependent care
- A relative who provides care (as long as the relative is not your dependent for income tax purposes) or a child or stepchild over age 19

REIMBURSEMENT

The City has contracted with Rocky Mountain Reserve, LLC (RMR) to administer the Flexible Spending Account program and to provide for reimbursement out of your account.

Once qualified expenses for heath care or dependent care have been paid, you must submit a completed Claim Form directly to RMR.. Be sure to attach the necessary documentation in the form of cancelled checks, statements, invoices and explanation of benefit forms. Claims for reimbursement will be processed daily. Reimbursement checks will normally be returned within 7 to 10 business days. Participants may check on the status of their account(s) by either calling RMR at 888-722-1223 or by going on-line at https://rockymountainreserve.com.

DEBIT CARDS

Debit cards are available from RMR for use with eligible health care and dependent care expenses at no charge. Debit cards are active for up to three years. Receipts may be requested by RMR in accordance with the federal regulations governing these accounts. *Failure to provide receipts as requested will result in the deactivation of your debit card until the requested documentation is submitted.* Debit card expenses that cannot be substantiated will be added back to your W-2 taxable income.

IMPORTANT LIMITATIONS AND RESTRICTIONS

The Spectrum Plan is governed by Section 125 of the Internal Revenue Code, which imposes strict rules and regulations.
Because employee premium contributions are made pre-tax under Spectrum, these restrictions apply as well to our medical, dental and vision elections. Contributions can be used only for charges incurred during that Plan Year and that year's grace period.

First, elections must be made in advance and cannot be retroactive. Newly hired employees must make elections during their first 31 calendar days of employment, with elections taking effect on the first day of the month following the date of enrollment. Current employees must register elections during Open Enrollment, in advance of the close of Open Enrollment. Eligible expenses are incurred once you are actually enrolled effective on the first of the month following application.

Second, elections are ***irrevocable***. Changes during a Plan Year are limited to qualifying changes in family status defined by the IRS, including: marriage or divorce, the death of a spouse or child, the birth or adoption of a child, or a change in the spouse's employment that impacts plan eligibility.

Such changes must be made **within 31 calendar days** of the event causing the change. You cannot change your Health Care Account contributions to an annualized amount that would be less than the amount of reimbursements made to you already during that year. The change in elections must also be **consistent** with the status change justifying the election change. For example, if your enrolled dependent child reaches age 26, you can remove the child from coverage but you cannot end your own coverage.

Third, contributions to your accounts cannot be transferred between accounts. For example, funds in your health care account can be used only for the reimbursement of health care expenses, and the same for dependent care expenses.

Fourth, funds left unused in your accounts at the end of each Plan Year are forfeited to the Plan. The Plan provides for a Grace Period until March 15 of the following year for you to incur eligible charges for reimbursement. For charges incurred during the Grace Period, you have until 90 days after March 15 to file claims with RMR. For charges incurred on or before December 31 of the Plan Year, you have 90 days following December 31 to file claims.

Employee Assistance Program

INTRODUCTION

The City pays the entire cost in the Employee Assistance Program (EAP). The EAP is offered through **Mines and Associates**, which maintains a network of outside counselors along the Front Range**.** To reach Mines & Assoc. EAP, call **800-873-7138** or visit their website at www.minesandassociates.com and enter "longmontcity". There is a wealth of information on their web site.

Who is eligible to use the EAP?
All Regular benefited and part-time non-benefited City employees are eligible to use EAP services. In fact, all family members (including parents of both yourself and your spouse) are eligible for up to 8 sessions per year to receive help with any given issue. Additional sessions can be used later in the year if another issue requires EAP use. Temporary employees may be authorized by HR to use the service. Contact your HR Partner if you are a temporary employee who needs the service.

When you call, the EAP will ask your name, your employer and the nature of your situation. The EAP will help you find a provider to meet your needs and give you information for setting an appointment. That provider will help you resolve your problem or refer you to the best available resource. If you need the help, make the call. This service is provided at no cost to you and your family.

What kinds of problems are handled by the EAP?
EAP is generally for issues that can be resolved in eight sessions. More serious issues may have to be transitioned to Kaiser. This is true especially of urgent/emergency situations, since the EAP cannot always accommodate immediate appointments due to high demand. This is often the case with behavioral health professionals and other specialist health care providers.

Some of the many issues that the EAP can help with include family problems, marital difficulties, financial pressures, work-related problems, depression, anxiety, insomnia, and concerns about the use of alcohol or other substances. Their experienced staff of counselors will help you find solutions to these and other issues.

Is use of the EAP confidential?
Absolutely! Although the City pays the entire cost of the EAP benefit, all services are provided in strict confidence. The City will not know about the counseling you and your family members receive through the EAP.

Do not hesitate to call.
All of us need help once in a while, and this is nothing to be ashamed of. If you are a manager or supervisor and you believe one of your employees could benefit from EAP services, you may certainly suggest the EAP to that employee. Employees are also able to suggest the EAP to a co-worker who seems to be having difficulty.

SOME OF THE ISSUES WITH WHICH THE EAP CAN ASSIST INCLUDE:

- Concern about someone's use of alcohol or drugs
- Stress management
- Parenting issues
- Grieving the loss of a loved one
- Worry about an elderly parent
- Family conflict
- Depression
- Anxiety
- Financial pressures
- Legal issues
- Conflict with co-workers
- Individual, family and marriage counseling
- You can also go on-line for information on these and other subjects.

General Employees Retirement Plan

(For all regular benefited employees, except uniformed Fire and Police)

PLAN HIGHLIGHTS

The City of Longmont General Employees Retirement Plan ("Plan") can help assure steady financial support during your retirement.

The plan is flexible enough to meet many of your individual needs, and it could be just the added security you need to make your retirement a comfortable one. You are fully vested after five years of credited service under the plan.

Because the Plan is intended to provide income security at retirement, **loans and other in-service withdrawals are NOT permitted.**

Participation in the Plan is mandatory for all regular benefited employees, except uniformed Fire and Police personnel. Your 2025 contribution to the Plan is 7.0% (6.0% if you are hired on or after January 1, 2012) of your base salary. The City contributes whatever added amount is necessary to fund the Plan. Although funding requirements may vary, City contributions are budgeted currently at 9.4% of eligible base salary.

Unlike many retirement plans such as 401(k)'s, the General Employees' Retirement Plan is a "defined benefit" plan rather than a "defined contribution" plan. As we will discuss later, the City's MOPC Plans are defined contribution plans.

The difference in these two types of plans is simple. In a defined benefit plan your benefit is based on a predetermined formula. In the case of the City's Plan, this formula includes years of service, average base salary and a multiplier. In a defined contribution plan, only the contribution levels are predetermined so that the actual benefit is equal to: contributions + investment gain/loss.

With the General Employees' Retirement Plan you can choose from a number of options to put together the retirement package that's right for you.

First, you decide when you want to retire. Your retirement date is the first of the month following you last day on payroll.

- ***Normal Retirement*** begins at age 65 with a full benefit, based on your years of credited service.
- ***Special Early Retirement*** offers a full benefit as early as age 55 with at least 25 years of credited service ("Rule of 80"). If you are hired on or after January 1, 2012, you can receive your full benefit as early as age 60, with 20 years of service. You can actually terminate before age 55 (60 if you are hired on or after January 1, 2012) if the sum of your age and credited service equals eighty (80), but you cannot begin to receive retirement payments before age 55 (60 if you are hired on or after January 1, 2012).
- ***Regular Early Retirement*** can begin as soon as you reach age 55 (60 if you are hired on or after January 1, 2012) and have at least five years of credited service.
- ***Delayed Retirement:*** working for the City past your normal retirement age, is another option you might prefer and you would continue to accrue benefits. However, not working and delaying retirement past age 65 will not increase your benefit.

Second, you can choose how you want to receive your benefit. However, once benefit payments begin you cannot change your payment option.

- You can receive payments for your lifetime only, with no continued payments after your death.
- You can receive reduced payments for your lifetime, with the added assurance that at least 120 monthly payments (10 years) will be made. This means if you die before receiving all 120 payments, your beneficiary will receive the remainder of the 10 years of payments. Afterwards, benefit payments stop.

- You can receive reduced payments for the rest of your lifetime and your beneficiary will continue to receive 100% or 50% of the reduced amount for his or her lifetime. These benefits are called Joint and Survivor benefits (J&S). If you are married at the time you retire, you must elect one of these options, unless your spouse signs a notarized waiver of his/her rights.

Third, you don't have to worry about losing your benefit if you die or leave City employment before retirement. The Plan has provisions to protect your benefits:

- If you terminate your employment before becoming eligible for retirement, but have completed at least five years of credited service, you'll still be eligible for a benefit when you reach your applicable retirement age.
- If you die before payments begin, the Plan will pay a benefit to your surviving spouse or beneficiary. Your survivors are always guaranteed at least two times the amount of your accumulated contributions.
- If you become disabled while working for the City, you may be eligible to receive a disability retirement benefit at age 65 or when payments stop under the City's Long Term Disability Insurance Plan, if that is later.

RETIREMENT BENEFITS

Normal Retirement Benefits at Age 65 or Later

The amount of your monthly benefit payment depends on your credited service and final average monthly pay at retirement. These factors are used in a formula to calculate your benefit.

The retirement plan has a formula for calculating your monthly benefit at normal retirement (age 65) and at delayed retirement (after age 65). The benefit amount is calculated in a form payable for your lifetime. Benefits that begin after age 65 are not adjusted upward. Therefore, you should notify the City of your desire to begin receiving benefits as early as possible.

The formula uses your years of credited service under the Plan and your final average monthly pay (FAMP) during the latter years of your career to calculate your monthly retirement benefit.

The formula for calculating your monthly normal or delayed retirement benefit is:

Monthly Benefit = 2.2% X FAMP X Credited Service

In the simplest terms, with 30 years of credited service at retirement, you will receive 66% (30 X 2.2%) of your final average monthly pay as retirement benefits, as shown here:

2.2% x $5,000 FAMP x 30 years = $3,300 in monthly retirement benefits under the Normal Form Single Life Benefit Payment Option.

You can elect reduced benefits to provide for a named beneficiary (usually a spouse), as described under the “Forms of Benefit Payments” Section on the next page. The benefit reduction is necessary, because benefits could be paid beyond your own lifetime. The actual amount of the reduction will depend on the relative ages of you and your named beneficiary and will be different for each couple.

Early Retirement Benefits

You may retire as early as age 55 (60 if you are hired on or after January 1, 2012) if you have at least five years of credited service. If you retire under regular early retirement and payments begin immediately, your benefit amount will be reduced. Under special early retirement, you may begin receiving unreduced benefits at age 55 (60 if hired on or after January 1, 2012) or above.

You may choose to retire and receive a regular early retirement benefit under the plan at any time between ages 55 and 65 if you have at least five years of credited service. The formula for calculating your regular early retirement benefit is the same as the normal retirement benefit formula described previously. The amount calculated will be payable at age 65.

If you want to have payments begin before age 65, the amount of your monthly benefit will be reduced to reflect the longer time that payments are expected to be made. The reduction factor is 3% (6% if you are hired on or after January 1, 2012) for each year benefit payments begin before age 65.

See the chart on the next page for additional information on early retirement reductions:

Percentage of Age-65 Retirement Benefit Payable Immediately at Ages 55-64 Percentages Shown for Employees Hired before and after January 1, 2012										
Age	64	63	62	61	60	59	58	57	56	55
Percent Payable (before **and after** 1/1/12 hire date)	97 **or** 94	94 **or** 88	91 **or** 82	88 **or** 76	85 **or** 70	82 N/A	79 N/A	76 N/A	73 N/A	70 N/A
George elects to take early retirement at age 60 with 17.5 years of credited service. He wants to begin receiving monthly benefits right away. His monthly retirement benefit payable at age 65 is calculated to be $600. George's monthly benefit beginning at age 60 is $510 ($600 x 85%). If he had been age 55 instead of 60 and started payment immediately, his benefit would have been $420 ($600 x 70%) per month. George was hired before January 1, 2012.										

Special Early Retirement ("Rule of 80")
Under special early retirement, you can retire early and receive unreduced benefits if you meet certain requirements of age and service during active employment.

You will receive 100% (no reduction) of your age-65 benefit if the sum of your age plus your years of service equals 80 or more with early retirement benefits beginning on the later of:

(a) termination of employment or
(b) attainment of age 55 (60 if hired on or after January 1, 2012)

FORMS OF BENEFIT PAYMENTS

There are several forms of payments available when you get ready to retire. You may elect to have benefits paid to you only or to you and a beneficiary. Once payments begin, the payment option cannot be changed.

The retirement plan has several ways in which your monthly benefit can be paid. When you get ready to retire, you *must elect* a form of payment in writing at least 30 days before you want the payments to begin. You may change the option you have elected, but this change must also be made at least 30 days before the first payment is due. Once payments begin, you cannot change your election. Elections must be filed with the Retirement Board through the Human Resources Department.

Spousal Consent: If you are married and want to receive benefit payments in any form other than a Joint and Survivor option with your spouse as beneficiary, your spouse must agree in writing to that form of payment. The agreement must be notarized or witnessed by a plan representative. The Human Resources Department has forms for this alternate designation, which must be returned at least 30 days before payments are to begin. Payment cannot begin until a properly completed form is received, and payments have been approved.

Single Life Benefit: You may elect to receive a monthly benefit for your lifetime only. The monthly payments stop when you die. There are no monthly survivor benefits (see "Minimum Payment" below). This is the form of payment for the benefit amount calculated by the plan's benefit formula.

Life and 10-Year Certain: The benefit is a reduced monthly payment to you for your lifetime. If you die before receiving 120 payments (10 years), your beneficiary will receive the remainder of the 120 payments. For example, if you die after receiving payments for 48 months, your beneficiary will receive the remaining 72 payments (120 minus 48). Afterwards, payments stop.

Joint and Survivor: The joint and 50%/100% survivor benefit pays an adjusted benefit to you for your lifetime. After your death, either 50% or 100% (whichever you initially elected) of your adjusted benefit will continue to your beneficiary for his or her lifetime. Upon the death of your beneficiary, payments will stop when they die. The joint and 50% or 100% survivor form of payment are the only forms of payment that married employees may elect without spousal consent.

Minimum Payment: In all cases, the minimum amount of benefits payable to you and/or your beneficiary (or your estate if your beneficiary dies before you) is the total of your accumulated contributions. Also, if the minimum periodic payment to you is less than $100, the Retirement Board may pay actuarially equivalent amounts quarterly, semi-annually, annually or in a single sum.

IF YOU LEAVE

If your employment with the City ends after five or more years of credited service, you will be entitled to a vested benefit, payable at age 65. If you elect to withdraw your own contribution plus credited interest, you forfeit any future benefit from the Plan.

Less Than Five Years of Credited Service

If you terminate your employment with the City before you are age 65 and you have less than five years of credited service and $1,000 in contributions, you will receive your accumulated contributions.

If your balance is $1,000 - $7,000 your contributions will be rolled over to an IRA, unless you elect otherwise **within 60 days** of your employment termination date.

Five or More Years of Credited Service
If you terminate your employment with the City before you are age 65, and you have at least five years of credited service, you have an option when you terminate your employment:

- You can leave your accumulated contributions on deposit in the retirement trust and become a "vested member."

OR

- You can elect to withdraw your accumulated contributions and give up your right to any other benefits under the Plan. If you are married and elect to withdraw your accumulated contributions of $7,000 or more your spouse must agree in writing because you are giving up rights to future benefits.

If you do not elect to receive your accumulated contributions within 90 days of your termination date, you automatically become a vested member. As a vested member, you may elect at any time prior to age 65 to receive your accumulated contributions, subject to the Spousal Consent rule. City contributions would be forfeited, and no additional benefits would be forthcoming from the Plan.

Vested Member Benefits
As a vested member in the Plan, you have the right to receive a retirement benefit at age 65. The amount of that benefit will be based on your accrued benefit on your termination date. You may elect to have your vested retirement benefit payments begin as early as age 55. However, payments that begin before age 65 will be smaller because they are expected to be paid over a longer period of time. See the earlier discussion of early retirement.

Reemployment of Former Participants
If you end your employment with the City before being eligible for a retirement benefit and are later rehired as a regular employee, your credited service for calculating future benefits will be determined by the break-in-service rules. See Plan Document for details.

Reemployment of Retirees
Sometimes former employees are rehired by the City after having retired. If you are re-employed as a regular employee covered by this Plan, your monthly benefit payments will stop while you are employed. When you retire again, your monthly benefit will be recalculated based on any additional credited service and your previous benefit payments.

Important Note:

The Plan information provided here is limited and does not include all information regarding the Plan. A summary plan description of the City of Longmont General Employees' Retirement Plan is available at any time on Inside Longmont or from the Human Resources Department. Any discrepancy between the information contained herein and the Plan Document will be governed by the Plan Document, which you can review at the Human Resources Department. Benefits are payable subject to the Plan's continued ability to pay.

General Employees Money Accumulation (or MOPC) Plan

(For all Regular Employees, except uniformed Fire and Police)

PLAN HIGHLIGHTS

The Money Accumulation Pension Plan for General Employees of the City of Longmont, commonly referred to as the MOPC Plan, was adopted by the City Council of Longmont as of January 1, 1980 as part of the City's withdrawal from Social Security. The Plan is one means of helping you establish a source of income for your retirement years. **Empower Retirement** provides administrative and record keeping services to the Plan. ***Loans are not permitted, and access to funds during active employment is limited solely to voluntary after-tax contributions.***

Participation in the Plan is mandatory for all benefited general employees. The City contributes 5% of your base salary to the Plan. You also contribute 5% (6% if you are hired on or after January 1, 2012). This Plan is called a "defined contribution" plan, because benefits are based on contributions and not a formula. Your actual benefit will be equal to contributions plus investment gain/loss. You select your mutual fund investments on-line at: https://participant.empower-retirement.com/ui/login-ui/#/login

PARTICIPATION

Your Participation in the Plan

Regular full-time or part-time benefit eligible employees, as defined in the Personnel Rules of the City, are required to participate in the Plan. You begin to participate on your date of employment (beginning January 1, 1980). You must complete an enrollment form when your employment begins.

Stopping Your Participation

Once you become a member of the Plan, you may not withdraw from membership or stop participating unless your employment with the City ends. If your employment ends and you are later re- employed with the City, you will again become a Plan participant.

BASIC CONTRIBUTIONS TO THE PLAN

You contribute pre-tax 5% (6% if hired on or after January 1, 2012) of your base pay and the City also contributes 5% of your base pay to provide your benefits.

Your Contributions
You make pre-tax basic contributions and may make after-tax voluntary, “catch-up” and rollover contributions to the Plan. Each type of contribution is described below. A separate account is kept for your basic contributions (voluntary, catch-up, or rollover if applicable) and the City’s contributions made on your behalf.

Basic Contributions Account
You and the City share the cost of funding the benefits you will receive when you retire. You contribute 5% (6% if you are hired on or after January 1, 2012) of your base compensation (pay) on a pre-tax basis to the Plan as a “basic” contribution.

For purposes of this Plan, “compensation” means your base monthly salary or wage paid by the City, including any amounts you may be contributing to another retirement plan or deferred compensation plan. The City contributes 5% of your base pay.

Voluntary Contributions Account
You may also make additional voluntary contributions in an amount of your choice, but your TOTAL annual contributions – employer, employee and additional voluntary – cannot exceed $70,000 or 100% of your base salary. Voluntary contributions are made on an after-tax basis.

Catch-up Contributions Account
In addition to voluntary contributions, you may make additional after-tax contributions to the Plan, called “catch-up contributions.” You may make catch-up contributions only if you did not make the full 10% voluntary contribution (the maximum amount allowed) at any time you were eligible to do so.

The purpose of the “catch-up contributions” is to allow you to bring your total voluntary contributions to the maximum amount you could have contributed as voluntary contributions under the Plan. The amount of catch-up contributions, if any, is determined by you.

However, the amount cannot exceed the amount you could have contributed if you had made voluntary contributions at the 10% rate during the entire time you were eligible to do so. The amount of your catch-up contributions may also be limited on an annual basis by Federal guidelines.

You may only make catch-up contributions when you are making your basic contribution and the maximum 10% voluntary contribution. If you want to make catch-up contributions, contact the Human Resources Department.

Rollover Contributions

The Plan will accept Member rollover (and direct rollover) contributions, provided the Retirement Board reasonably concludes that the contribution is an eligible rollover distribution from a qualified plan (or an amount distributed from a conduit Individual Retirement Account as provided by Code Section 408) and that such contribution will not affect the qualification of this Plan or create adverse consequences for the City or the Plan.

Such rollover (and direct rollover) contributions are subject to the same withdrawal and distribution rules that apply to City Contributions for this Plan. If you want to make a rollover contribution, contact the Human Resources Department.

Changing Your Voluntary Contribution Rate

You may elect to change the amount of your Voluntary Contributions at any time by notifying the Retirement Plan Specialist.

Investment Options and Earnings on Your Contributions

Your contributions and the City's contributions made on your behalf are deposited in an account maintained in your name and invested in mutual fund investments selected by you on-line. These investment funds have varying degrees of risk and earnings objectives. If you do not select any funds, your contributions will be invested in a Target Date Fund appropriate for your age.

Your ultimate benefit equals contributions + investment gain/loss. You should monitor your investments periodically and meet with an Empower representative to discuss your investments and their performance. Meeting dates/times are announced by e-mail.

Plan Fees and Fund Performance

Fees are paid to the Plan's Trustee/Record Keeper, as well as to the investment funds. The MOPC Plan Board monitors regularly these fees along with the investment performance of our funds. Based on information available currently, our plan fees are among the lowest in the industry for comparable plans. You are encouraged to attend the Board's quarterly meetings to learn more.

VESTING AND SERVICE CREDIT

"Vesting" means "ownership" of your benefits under this plan. You become vested in the City's contributions based on your years of service with the City.

Vesting Your Contributions

You are always 100% vested in the contributions that you make, including mandatory, voluntary, catch-up and rollover. Being 100% vested means your contributions and rollover contributions are always yours and cannot be taken from you.

Vesting City Contributions
You will be vested in the City's contributions to your account according to your years of vesting service, as follows:

Years of Vesting Service	Percent Vested
Less than 1	0%
1	25%
2	50%
3	100%

You will become 100% vested in the City's contributions earlier than the vesting schedule outlined above if any of the following occurs:

- You die
- You become disabled, as defined by the Plan
- You reach your Early Retirement Date at age 55
- You reach Normal Retirement Age 65
- This Plan ends, or the City no longer makes contributions to the Plan

WITHDRAWALS DURING EMPLOYMENT

Because the plan is a retirement plan intended to provide income once you retire, access to funds during employment is limited.

What You May Withdraw
You may request a withdrawal of only all or a portion of your Voluntary Contributions Account balance and your Catch-up Contributions Account balance, if any. Investment earnings on Voluntary Contributions are subject to ordinary income tax. You may not withdraw any other portion of your account balance.

Loans
The plan does not have a loan provision, because the plan is intended to provide income during retirement.

WHEN YOU RECEIVE YOUR MONEY

You will receive your contributions and your vested portion of the City's contributions when you retire, leave employment, become disabled, or die while employed with the City and participating in the Plan. You may receive your benefit in a lump sum or in regular installment payments. Your beneficiary receives your full account balances if you die before retirement.

When You Retire, Leave Employment, or Become Disabled When you retire or otherwise leave employment with the City, or become disabled, you are eligible to receive all of your Basic, Voluntary, Catch-up and Rollover Contributions Account balances, plus earnings, and the **vested portion** of the City Contributions Account balance, plus interest. By law, you must begin receiving **minimum distribution payments** no later than April 1 of the year following the year in which you reach age age 73 on or after January 1, 2025.

Your balance can also be rolled over tax-free to another retirement plan or IRA. Be aware of and understand completely the fees you will pay to another plan. Money withdrawn and not rolled over is subject to ordinary income tax, plus a 10% premature withdrawal penalty if you are under age 59 ½.

If You Die
If you die while you are employed with the City and participating in the Plan, your beneficiary will receive all of your Basic, Voluntary, Catch-up, and Rollover Contributions Account balances, which includes earnings. In addition, your beneficiary will receive all of the City Contributions Account balance, which includes investment earnings.

Important Note:

The information provided here is summary in nature. In the event of a discrepancy between this information and the actual MOPC Plan Document, the Plan Document shall govern. A summary plan description is available on inside Longmont or from Human Resources.

FPPA Statewide Retirement Plan

(Uniformed Fire and Police Personnel Only Hired after 11/09/2021)

PLAN HIGHLIGHTS

The FPPA Statewide Defined Benefit Plan for Fire and Police personnel was adopted by the City in November 2021 for sworn police officers and firefighters of Longmont who were hired after November 9, 2021. The Plan is one means of helping you establish a source of income for your retirement years and is currently provided through FPPA. Effective January 1, 2025, Members of the Statewide Defined Benefit, Hybrid, and Hybrid Money Purchase Plans were merged into the newly formed Statewide Retirement Plan. Visit FPPAco.org for further details or log into your FPPA Member Account Portal (MAP) for information specific to you.

Participation in the Plan is mandatory for all sworn police officers and firefighters. Employees under this plan contribute 12% of base salary and the City contributes 10.5% to the Plan. See Police & Fire Retirement Matrix (last page of this booklet) for further details or FPPA materials for details or visit FPPAco.org.

Under this plan, the benefit is "defined" at the outset of your employment. Contributions go into the plan to fund the established benefit. The benefit at retirement equals a certain percentage of your base salary for your lifetime.

Members who have attained at least 25 years of service credit in the plan and are also at least age 55, or meet the Rule of 80, qualify for normal retirement. Members with a minimum of 5 years of service qualify for a vested retirement payable when the member reaches age 55. Members may also qualify for an early retirement if they have at least 5 years of service and are at least age 50. Early retirement benefits are actuarially reduced since benefits are paid prior to obtaining normal retirement age.

Your monthly benefit is based on the average of your highest 3 years' base salary (HAS) in the plan and is calculated at 2% per year for the first 10 years of service credit plus 2.5% per year for each additional year of service credit. Benefits are calculated using all service credit in the plan, whether earned or purchased.

If you do not want to collect your normal retirement benefit at the time of your normal retirement, you may defer receipt of your benefit up to age 65 and receive an increased amount due to the later receipt of the benefit. This increase is the actuarial equivalent of the normal retirement benefit.

Employment with other Colorado fire or police departments will count toward your retirement if you are covered by this plan in the other employment and you did not take a refund of your contributions upon termination from that employment.

Note: The FPPA Board reviews retirement age each year in the context of the annual actuarial study and has the discretion to set the age anywhere between 55 and 60, depending on actuarial expense and the current cost of the plan. The current age is 55, or ages 50 to 55, so that when the age is added together with years of service, the sum equals 80. No change to normal retirement is anticipated at this time.

CONTRIBUTIONS

The mandatory member contribution in 2025 is 12.1%. The 2025 employer contribution is 10.6% for DB; 12.1% for Hybrid; 12.1% for Hybrid MP.

Contributions are based on base salary. Generally speaking, "base salary" includes base pay, longevity pay, and shift differential.

Base salary does not include overtime pay, step-up pay or other pay for temporarily acting in a higher rank (a member is deemed temporarily acting in a higher rank if the appointment to the rank is anticipated to last less than six months), uniform allowances, accumulated sick pay or accumulated vacation pay, or other forms of extra pay. (The full definition can be found in the FPPA Rules at www.FPPAco.org.)

REFUND OF CONTRIBUTIONS

If you terminate employment before accruing 5 years of service credit, or if you terminate employment and are vested but do not wish to receive a retirement benefit, you may obtain a refund of contributions. Your member contributions will be refunded, plus 5% as interest. (Your employer's contributions are not refunded.)

REQUIREMENTS FOR VESTED RETIREMENT

Upon termination after at least 5 years of service credit in the plan, you are vested and eligible for a partial retirement benefit. When you reach age 55, you may draw a lifetime benefit. The benefit is based on the average of your highest three years' base salary in the plan and is calculated at 2% per year for each year of service credit up to 10 years, then 2.5% for each year of service credit thereafter.

REQUIREMENTS FOR EARLY RETIREMENT

You may retire early if:

1. You have 30 years of service credit (regardless of your age); or
2. You are at least age 50 with a minimum of five years of service credit.

The benefit is based on the average of your highest three years' base salary in the plan and is calculated at 2% per year for each year of service credit up to 10 years, then 2.5% per year for each year worked thereafter. You may begin receiving your benefit immediately (under normal or vested retirements, you must wait until age 55 to receive the benefit).

However, the early retirement benefit that you would have received at normal retirement (age 55) is reduced on an actuarial equivalent basis to reflect the early receipt of the benefit.

REQUIREMENTS FOR DEFERRED RETIREMENT

Any member retiring and eligible for a normal or vested retirement benefit may elect to defer receipt of such benefit until as late as age 65. If you elect this option, your annual deferred retirement pension will be increased to be the actuarial equivalent of your normal or vested retirement pension. In other words, you receive an increased benefit amount since you are receiving the benefit payment later.

DEFERRED RETIREMENT OPTION PLAN (DROP)

Once you meet the requirements for a normal retirement or vested retirement and age 55 or early retirement, and if your employer approves your written DROP Agreement, you can elect to enter the Deferred Retirement Option Plan (DROP) in lieu of accruing the additional percentage for your retirement benefit.

When you enter DROP, instead of terminating employment and receiving a retirement benefit, you choose to continue employment for a specified period of time not to exceed five years. Your retirement benefit is calculated based on your highest three years' base salary in the plan, years of service credit, and post-retirement survivor option chosen at the time of entry into DROP. While participating in the DROP, you earn no additional service credits or benefits under the Plan.

During this period, your retirement benefit, as well as your employee pension contribution, is paid into the DROP account. The employer pension contribution ceases upon entry into DROP.

You direct the investment of your DROP account; a variety of investment options is available through the FPPA Self Directed Investment Fund and its record keeper, Fidelity Investments.

At the end of the specified period, you cease employment and receive the accumulated amount in the DROP account, net of investment earnings, losses and fees. You also begin receiving your defined benefit monthly pension.

Payments from the DROP account can be made in periodic payments, a lump sum distribution, or a combination of the two (i.e., partial lump sum with the remainder in periodic payments).

As an alternative, you can convert some or all the DROP and/or Money Purchase Component accounts to a "monthly lifetime benefit" by transferring all or a portion of your DROP/Money Purchase Component account to the defined benefit component of the plan. Once converted, the money is considered to be a portion of the member pension and may be adjusted for an election of a survivor benefit payout option and benefit adjustments.

POST-RETIREMENT SURVIVOR BENEFITS

A survivor benefit from normal, vested or early retirement is paid according to the benefit option selected at the time of retirement or entry into DROP. You can elect to receive a full, unreduced pension (Normal Option Benefit) for your lifetime only or choose among five retirement options that provide a survivor benefit:

1. 100% Survivor Benefit: A reduced monthly benefit payable for life. Upon your death, the same amount is paid to your beneficiary for life.
2. 50% Survivor Benefit: A reduced monthly benefit payable for life. After your death, one-half of that amount is paid to your beneficiary for life.
3. 50% Last Survivor Benefit: You and your beneficiary jointly receive a reduced monthly benefit payable for life. After the death of either you or your beneficiary, one-half of that amount is paid to the survivor for life.

4. 100% Survivor Benefit With the “Pop-Up” Provision: A reduced monthly benefit payable for life; plus after your death, the same amount is paid to your beneficiary for life. If your beneficiary dies before you, this benefit “pops-up” to the unreduced “normal option” amount.
5. 50% Survivor Benefit With the “Pop-Up” Provision: A reduced monthly benefit payable for life. After your death, one-half of that amount is paid to your beneficiary for life. If your beneficiary dies before you, this benefit “pops up” to the unreduced “normal option” amount.

The amount of your reduced benefit depends on your age and your beneficiary’s age at the time of your retirement.

Each of these options, as with the standard benefit, is of equal value at the day benefit payments begin.

If the total amount of pension payments paid to the member and beneficiary does not equal the member’s contributions to the plan (including any amount transferred into the plan to purchase service credit), the difference, plus 5% as interest, will be paid to the member’s or beneficiary’s estate.

FOR MORE INFORMATION ABOUT FPPA RETIREMENT PLANS, VISIT www.FPPAco.org.

FPPA Statewide Retirement Plan – Money Purchase Component

(Uniformed Fire and Police re-entry personnel who exited the City’s New Hire plans)

Effective January 1, 2025, Members of the Statewide Defined Benefit, Hybrid, and Hybrid Money Purchase Plans were merged into the newly formed Statewide Retirement Plan. Visit www.FPPAco.org for further details.

STATEWIDE RETIREMENT PLAN – Money Purchase Component

The Statewide Hybrid Plan – Money Purchase Component, is an individual, self-directed retirement account that is available to a member at retirement until it is depleted. A money purchase plan is also referred to as a defined contribution plan. In this type of plan the contribution is “defined,” and the benefit becomes the amount of cash available (contributions plus earnings or losses less expenses) at termination of service.

Contributions
Each member contributes 12.1% of monthly base salary to the plan, and the City contributes 12.1%.

Generally speaking, “base salary” includes base pay, longevity pay, and shift differential. Base salary does not include overtime pay, step-up pay or other pay for temporarily acting in a higher rank (a member is deemed temporarily acting in a higher rank if the appointment to the rank is anticipated to last less than six months), uniform allowances, accumulated sick pay or accumulated vacation pay, or other forms of extra pay. (The full definition can be found in the FPPA Rules at www.FPPAco.org.)

Refund of Contributions
Upon termination of employment, you do not receive a “refund” of contributions under this plan. Rather, you will receive a distribution based on the vested amount of funds in your account.

Requirements for Vested Retirement
From the first day of membership in this component of the hybrid plan, you are fully vested in your member contributions and any amounts "rolled over" to the plan for your account.

Employer contributions are fully vested in the event of a permanent occupational disability, total disability or death; benefits payable from the Statewide Death and Disability (SWD&D) Plan.

You also are 100% vested upon and after attaining Normal Retirement (age 55, regardless of years of service). Upon termination of employment for any other reason, you will be vested in employer contributions according to this schedule:

Years of Service	Vested %
Less than 1	0%
1 but less than 2	20%
2 but less than 3	40%
3 but less than 4	60%
4 but less than 5	80%
5 or more	100%

Your vested benefit (account balance) becomes eligible for distribution upon death, permanent occupational or total disability, retirement, or termination of employment. Adjustments are made for gains or losses from investments and plan expenses.

Requirements for Early Retirement
Because you are eligible for a benefit regardless of your age and years of service, under this component of the hybrid plan there is neither an "early" retirement nor a "normal" retirement of the type provided under the Statewide Hybrid Defined Benefit Component. Tax penalties may be imposed for early retirement or distribution.

Post-Retirement Survivor Benefits
You may designate a beneficiary to receive the vested balance in your money purchase account upon your death.

If you die after the commencement of benefit payments from the plan, the remaining funds to which you are entitled will be distributed to your beneficiary at least as rapidly as under the method of distribution that was in effect on the date of your death. If you die before the commencement of benefit payments, your beneficiary will select a method of distribution of the funds in your account.

Upon your death, your beneficiary may reallocate the investment of your funds to different investment options.

If you have not elected a beneficiary or if your beneficiary has died before you, the distribution is made to your estate in a lump sum.

Fees
The annual administrative fee for this plan is a flat $10.00 plus an asset- based fee of 0.104% or approximately $1.04 for every $1,000 invested. The flat fee is deducted from your account in January. The asset-based fee is deducted quarterly, so a fee of 0.026% is deducted in March, June, September, and December of every year.

In addition to the investment menu, FPPA also offers a brokerage window called BrokerageLink. While there is no administrative fee specific to the BrokerageLink account, trading fees apply.

All mutual funds charge their shareholders an annual fee called an expense ratio. The range of expense ratios based on the standard plan investment options can be found in the Quarterly Performance Update.

STATEWIDE RETIREMENT PLAN - HYBRID COMPONENT

A hybrid plan is a combination of a money purchase plan and a defined benefit plan. A portion of the contribution goes to fund a defined benefit, which is a monthly benefit and is payable for the retiree’s lifetime, and the remainder of the contribution, it applicable, funds a money purchase account that is invested and available (contributions and earnings or losses less expenses) at retirement or termination of service.

With the defined benefit component of the hybrid plan, the **benefit** is “defined” at the outset of your employment.

Contributions go into the plan to fund the established benefit. The benefit at retirement equals a certain percentage of your base salary for your lifetime.

Members who have attained at least 25 years of service credit in the plan and are also at least age 55, qualify for normal retirement.

Your monthly defined benefit is based on the average of your highest 3 years' base salary in the plan and is calculated at 1.5% per year for each year of service credit in the plan. Benefits are calculated using all service credit in the plan, whether earned or purchased.

If you do not want to collect your normal retirement benefit at the time of your normal retirement, you may defer receipt of your benefit up to age 65 and receive an increased amount due to the later receipt of the benefit. This increase is the actuarial equivalent of the normal retirement benefit. Under this plan, your retirement benefit is "defined" at the outset of your employment. Your retirement benefit is paid for your lifetime.

Employment with other Colorado fire or police departments will count toward your retirement if you are covered by this plan in the other employment, and you did not take a refund of your contributions upon termination from that employment.

Contributions
The mandatory member contribution is 12.1%. The 2025 employer contribution is 12.1%.

Contributions are based on base salary. Generally speaking, "base salary" includes base pay, longevity pay, and shift differential.

Base salary does not include overtime pay, step-up pay or other pay for temporarily acting in a higher rank (a member is deemed temporarily acting in a higher rank if the appointment to the rank is anticipated to last less than six months), uniform allowances, accumulated sick pay or accumulated vacation pay, or other forms of extra pay.

Refund of Contributions
If you terminate employment before accruing 5 years of service credit or you terminate employment and are vested but do not wish to receive a retirement benefit, you may obtain a refund of contributions. Your member contributions will be refunded, plus 5% as interest. (Your employer's contributions are not refunded.)

Definition of Normal Retirement
Normal Retirement is defined as Age 55 and 25 years of service or meeting the Rule of 80.

Requirements for Vested Retirement
Upon termination after at least 5 years of service credit, you are vested and eligible for a partial retirement benefit. When you reach age 55, you may draw a lifetime benefit. The benefit is based on the average of your highest three years' base salary in the plan and is calculated at 1.5% per year for each year of service credit in the plan.

Requirements for Early Retirement
You may retire early if:

1. You have 30 years of service credit (regardless of your age); or
2. You are at least age 50 (with a minimum of five years of service credit).

The benefit is based on the average of your highest three years' base salary in the plan and is calculated at 1.5% per year of service credit. You may begin receiving your benefit immediately (under normal or vested retirements, you must wait until age 55 to receive the benefit).

However, the early retirement benefit that you would have received at normal retirement (age 55) is reduced on an actuarial equivalent basis to reflect the early receipt of the benefit.

Requirements for Deferred Retirement
Any member retiring and eligible for a normal or vested retirement benefit may elect to defer receipt of such benefit until as late as age 65. If you elect this option, your annual deferred retirement pension will be increased to be the actuarial equivalent of your normal or vested retirement pension. In other words, you receive an increased benefit amount since you are beginning the benefit payment later.

Deferred Retirement Option Plan (DROP)
Once you meet the requirements for a normal retirement, early retirement or vested retirement and age 55 and if your employer approves your written DROP Agreement, you can elect to enter the Deferred Retirement Option Plan (DROP) in lieu of accruing the additional percentage for your retirement benefit.

When you enter DROP, instead of terminating employment and receiving a retirement benefit, you choose to continue employment for a specified period of time not to exceed five years. Your retirement benefit is calculated based on your HAS, years of service credit, and post-retirement survivor option chosen at the time of entry into DROP.

While participating in the DROP, you earn no additional service credits or benefits under the Defined Benefit component.

During this period, your retirement benefit, as well as your employee pension contribution, is paid into the DROP account. The employer pension contribution ceases upon entry into DROP.

You direct the investment of your DROP account; a variety of investment options is available through the FPPA Self Directed Investment Fund and its record keeper, Fidelity Investments.

At the end of the specified period, you cease employment and receive the accumulated amount in the DROP account, net of investment earnings, losses and fees. You also begin receiving your defined benefit monthly pension.

Payments from the DROP account can be made in periodic payments, a lump sum distribution, or a combination of the two (i.e.: partial lump sum with the remainder in periodic payments).

As an alternative, you can convert the DROP account to a “monthly lifetime benefit” by transferring all or a portion of your DROP account to the defined benefit component of the plan. Once converted, the money is considered to be a portion of the member pension and may be adjusted for an election of a survivor benefit payout option and benefit adjustments.

Post-Retirement Survivor Benefits

A survivor benefit from normal, vested or early retirement is paid according to the benefit option selected at the time of retirement or entry into DROP. You can elect to receive a full, unreduced pension (Normal Option Benefit) for your lifetime only or choose among five retirement options that provide a survivor benefit:

1. 100% Survivor Benefit: A reduced monthly benefit payable for life. Upon your death, the same amount is paid to your beneficiary for life.
2. 50% Survivor Benefit: A reduced monthly benefit payable for life. After your death, one-half of that amount is paid to your beneficiary for life.
3. 50% Last Survivor Benefit: You and your beneficiary jointly receive a reduced monthly benefit payable for life. After the death of either you or your beneficiary, one-half of that amount is paid to the survivor for life.
4. 100% Survivor Benefit With the “Pop-Up” Provision: A reduced monthly benefit payable for life; after your death, the same amount is paid to your beneficiary for life. If your beneficiary dies before you, this benefit “pops-up” to the unreduced “normal option” amount.
5. 50% Survivor Benefit With the “Pop-Up” Provision: A reduced monthly benefit payable for life. After your death, one-half of that amount is paid to your beneficiary for life. If your beneficiary dies before you, this benefit “pops up” to the unreduced “normal option” amount.

The amount of your reduced benefit depends on your age and your beneficiary’s age at the time of your retirement.

Each of these options, as with the standard benefit, is of equal value at the day benefit payments begin.

If the total amount of pension payments paid to the member and beneficiary does not equal the member's contributions to the plan (including any amount transferred into the plan to purchase service credit), the difference, plus 5% as interest, will be paid to the member's or beneficiary's estate.

FOR MORE INFORMATION ABOUT FPPA RETIREMENT PLANS, VISIT www.FPPAco.org.

Police and Fire Money Purchase Plan

(Uniformed Fire and Police Personnel Only Hired Prior to 11/10/2021)

PLAN HIGHLIGHTS

The 401 Money Purchase Plan for Fire and Police personnel was adopted by the City as a replacement for the Colorado Fire and Police Pension Association ("FPPA") Plan for sworn police officers and firefighters of Longmont who were hired after April 7, 1978 and prior to 11/10/2021. The Plan is one means of helping you establish a source of income for your retirement years and is currently provided through the MissionSquare Retirement Corporation (formerly ICMA-RC).

Through the Plan, you and the City set aside money during the time you are working to provide income for you after you retire. The intent of the Plan is to help provide for your future financial security. Therefore, the Plan does not provide for loans or other forms of in-service withdrawals, except in complying with the terms of a Qualified Domestic Relations Order (QDRO).

Participation in the Plan is mandatory for all sworn police officers and firefighters. Employees under this plan contribute 12% of your base salary and the City contributes 13.7% to the Plan. This plan is classified as a "defined contribution" plan, meaning that the contribution levels for both you and the City are defined. The actual benefit that you receive from the Plan will be based in part on your investment decisions and the gains/losses generated by those investments.

PARTICIPATION

Your Participation in the Plan

Uniformed police officers and firefighters are required to participate in the Plan if hired prior to 11/10/2021. You begin to participate on your date of employment (beginning April 7, 1978). You must complete an enrollment form when your employment begins.

Stopping Your Participation
Once you become a member of the Plan, you may not withdraw from membership or stop participating unless your employment with the City ends. If your employment ends and you are later re- employed with the City, you will again become a Plan participant.

MONEY PURCHASE PLAN

What is a money purchase plan?
A Money Purchase Plan is a retirement plan that is "qualified" under Section 401(a) of the Internal Revenue Code. Each participant has a plan account to which contributions are made. Ultimately Plan benefits are equal to contributions + investment gain/loss.

As a qualified plan participant, you are not taxed on City contributions or mandatory contributions made by you, nor upon the earnings on such contributions, until the funds are withdrawn, usually at retirement when you may be in a lower tax bracket.

CONTRIBUTIONS

What types of contributions can be made? The City makes contributions to your account in the amount of 12.1% of your base salary. You are required to make a pre-tax mandatory contribution of 12% of your base salary.

You may also make additional voluntary contributions in an amount of your choice, but your TOTAL annual contributions – employer, employee and additional voluntary – cannot exceed $70,000 or 100% of your base salary. Voluntary contributions are made on an after-tax basis.

How are City contributions treated for tax purposes? Contributions made by the City to your account are not taxed until you receive them, usually at retirement when you may be in a lower tax bracket. Earnings on such contributions grow on a "tax-deferred" basis.

Are my contributions subject to taxes?
Pre-tax mandatory contributions made by you are not subject to current federal and state taxes. The full amount of your pre-tax contributions is deducted from your income for tax purposes. This results in a decrease in your taxable income. In addition, your take- home pay will be greater than if you made contributions with after- tax dollars.

Voluntary or after-tax contributions are subject to current federal and state taxes. The full amount of such contributions is deducted from your pay after all withholding is calculated.

May I make additional contributions?
You can make additional voluntary contributions in an amount of your choice, but your TOTAL annual contributions – employer, employee and additional voluntary – cannot exceed $70,000 or 100% of your base salary. Voluntary contributions are made on an after-tax basis. Earnings on your voluntary after-tax contributions are tax-deferred.

You may increase or decrease the amount of these voluntary contributions at any time. You may also start or discontinue voluntary contributions at any time.

How is my account activity reported?
On a quarterly basis, MissionSquare will send you a statement that summarizes all account activity. Your statement details all contributions, transfers, earnings, fees and disbursements that occur in your account during the quarter. The performance of the investment funds is also summarized and sent to you each quarter.

You can access your account balance on a daily basis by calling the MissionSquare 24-hour, toll-free at 1-800-669-7400 or on-line at www.missionsq.org

May I roll over money from another plan?
If you have a balance in another plan that qualifies as an eligible rollover distribution according to IRS regulations, you may move your assets to this plan. For more information or assistance with your rollover, please contact MissionSquare Customer Service, toll- free at 1-800-669-7400.

May I also contribute to the City's 457 Plan with MissionSquare?
You may become a participant and contribute to the City's 457 plan with MissionSquare. This voluntary plan would allow you to make additional contributions on a pre-tax basis with tax-deferred investment growth. See Fire CBA for mandatory contribution amounts.

INVESTMENT OPTIONS AND FEES

What are my investment options?
The Plan offers a broad range of mutual fund investment options in various asset classes. Available funds are subject to change, and information is available in your enrollment kit, on line or by phone. If you do not elect an investment fund, your contributions will go into the most appropriate Milestone Fund for your age. You can change your elections on-line at www.missionsq.org

There is also an option to establish an individual brokerage account through MissionSquare for mutual funds not included on the list of basic funds. Additional fees may apply.

The range of funds enables you to select and combine investments from well-defined options and strategies. Diversity among funds has been thoughtfully and carefully designed to help protect and invest participant dollars effectively. The Model Portfolio funds are a preset selection of Vantagepoint funds, rebalanced automatically.

How often may I change my investment allocations?
Your investment allocation for crediting ongoing contributions into one or more of the funds may be changed at any time by entering the change by phone at 1-800-669-7400, or on the MissionSquare website at www.missionsq.org. Some funds limit the frequency with which changes can be made. Contact MissionSquare for details.

What investment fund transfers are permitted for my existing account balance?
You may transfer existing assets from one investment option to another without limitation as frequently as you wish, except for certain restrictions on competing funds. Changes may be made at any time by phone, the web site or by submitting a completed *401 Employee Fund Transfer Form*. For details on restrictions on competing funds (concerning the Cash Management, PLUS and certain international funds), and information on investments in the Trust, please contact MissionSquare directly.

What are my fees?
Fees are paid both to MissionSquare and the investment funds. The Retirement Board monitors these fees carefully. Based on current industry information, our fees are among the lowest. You are encouraged to attend the Retirement Board's quarterly meetings to learn more about how we are keeping your fees low.

VESTING

What is vesting?
Vesting means ownership of the assets in your plan. Vesting is based on your length of service and determines the percentage of the employer account to which you will be entitled when you leave employment.

Do I own the contributions I make into my account? Yes, you are always 100% vested in your own employee contributions and the earnings on those contributions.

When am I fully vested in City contributions to my account? You gain ownership of City contributions to your account and the earnings on those contributions based on your years of service with the City. The following table shows the vesting schedule.

Years of Service	Percent Vested
3 years	60%
4 years	80%
5 years	100%

Are there any special circumstances concerning vesting? If you attain normal retirement age 50, become disabled or die, while actively employed by the City, your account becomes 100% vested, regardless of your term of employment.

When are assets in my account payable to me?
In general, you are eligible to withdraw vested assets from the plan upon separation from service (whether voluntary or otherwise), disability or retirement. Your beneficiary becomes eligible in the event of your death. You should retain your pay-out statement for future use for tax purposes and Social Security.

How do I withdraw my assets?
Upon your termination of employment or retirement, you may request a MissionSquare *401 Money Purchase Plan Benefit Withdrawal Materials* packet from the Human Resources Department or from MissionSquare. The information in this packet details the information you will need. During active service, assets may be withdrawn only subject to a Qualified Domestic Relations Order (QDRO).

Special Note: Depending on the type of withdrawal you request, your payment may be subject to 20 percent federal tax withholding if you elect to directly receive funds that are eligible for rollover to another employer plan or an IRA. Please consult the *Special Tax Notice Regarding Plan Payments* included in the *401 Money Purchase Plan Benefit Withdrawal Materials* packet.

Are there any taxes or penalties on funds withdrawn after termination of employment but before retirement?
Pre-tax contributions and all earnings are subject to federal, state and local income taxes when withdrawn. Generally, taxable funds withdrawn before age 59 ½ are also subject to an IRS tax penalty of 10 percent, in addition to the tax normally paid on the amount. In-service withdrawals are not permitted, unless required to satisfy a Qualified Domestic Relations Order (QDRO).

Are there any special payout regulations if I am married? Although the Plan requires that you name a spouse your beneficiary, the manner in which you withdraw your account does not require spousal approval.

How will my retirement benefit be paid to me? MissionSquare offers a variety of options to meet a participant's individual retirement needs. You may choose from the following:

- Periodic payment—MissionSquare can make monthly, quarterly, semi-annual (at six-month intervals only) or annual payments until your assets are fully paid out.
- One lump sum—either partial or total distribution of your account balance.
- Annuities—MissionSquare can help you arrange the purchase of an annuity through a life insurance company. Be aware of annuity costs.
- Rollover—to another qualified plan that accepts rollovers or to an IRA. Be aware of the fees that plan charges.

What options are available if I change jobs and don't want to start receiving benefits?
You may leave your assets in the City's plan if your vested balance is over $5,000. You may also transfer all or part of an "eligible rollover distribution" to another employer's qualified plan or to an IRA. Eligible rollover distributions are generally all distributions unless they are:

1. Return of nontaxable employee contributions,
2. Regular, periodic payments over long periods, such as life expectancy or 10 years or more, or
3. Required minimum distribution payments made to participants age 73 beginning January 1, 2025.

What if my vested balance is not more than $7,000?
If, when you leave employment with the City, your total vested account balance is not more than $7,000, you will automatically be paid all the vested funds in your account as soon as possible. You do not have the option of keeping your assets in your account and delaying payment, but you may choose to transfer the taxable portion to a new employer's qualified plan or an IRA.

WITHDRAWING YOUR FUNDS: SPECIAL CIRCUMSTANCES

What if I am subject to a Qualified Domestic Relations Order (QDRO)?

A QDRO relates to the provision of child support, alimony payments, or marital property rights of a spouse. The QDRO recognizes an alternate payee's right to receive some or all of the plan benefits payable to you. Colorado participants are cautioned that state law may have an impact on payment to former spouses under QDROs. You are strongly encouraged to contact MissionSquare when a QDRO is anticipated to avoid any foreseeable problems.

MissionSquare will distribute the funds according to qualified orders only with City approval. **No other in-service withdrawals or loans are available, because the Plan is intended to provide income at retirement.**

What if I become disabled?
In the event of permanent and total disability prior to retirement age, you become 100 percent vested in your account balance and may withdraw your funds.

What happens in the event of my death prior to beginning distributions?
In the event of your death, your eligible beneficiary receives your funds. If you are married, your spouse is automatically your beneficiary.

Special Note:

The Plan information provided here is limited and does not include all information regarding the Plan. A summary plan description of the City of Longmont Police Pension Plan and Fire Employee's Pension Plan are available at any time from the Human Resources Department. Any discrepancy between the information contained herein and the Plan Document will be governed by the Plan Document.

Deferred Compensation or 457 Plan

HOW IT WORKS

What is deferred compensation?

Deferred compensation is a voluntary program that allows you to save and invest today for your retirement. Federal and state income taxes are deferred until your assets are withdrawn, usually during retirement when you may be in a lower tax bracket. The City's plan is currently being offered through MissionSquare Retirement Corporation (formerly ICMA-RC). A Roth component is also available.

How does deferred compensation work?

Under Section 457 of the Internal Revenue Code, you may defer or contribute each year a maximum of 50 percent of your pre-deferral taxable income or an annual dollar limit, whichever is less. The dollar limits are subject to change each year by IRS regulation.

Current annual contribution limits (deferred + Roth) are:

Normal Contribution:	$23,500 *plus*
Catch-up Contribution (age 50 and over):	$ 7,500
OR	
Pre-retirement Catch-up (limited availability)	$31,000
(Contact MissionSquare for information on the last option.)	
Super Catch-up (Age 60-63)	$11,250

Participation in the plan is voluntary and is handled through payroll deduction so your taxes are reduced each pay period by pre-tax deferrals. The plan allows you to increase, decrease, stop and restart contributions as often as you wish, without fees or penalties.

Is a 457 plan a good deal?

A 457 plan offers many advantages:

- You reduce your current income taxes while you boost your retirement savings.
- Your earnings accumulate tax deferred.
- Use the Roth option to make after-tax contributions, and at retirement withdraw your balance tax-free.
- If you are over 50 or within three years of your normal retirement age and already contributing the maximum to your plan, you are allowed to make additional "catch-up" contributions.
- It's portable. If you change jobs, you can consolidate your savings in another public sector employer's 457 plan, a qualified 401 plan, a tax-sheltered 403(b) annuity plan, or a Traditional IRA.

A GREAT SAVINGS TOOL

How does deferred compensation beat conventional savings? In two ways. First, deferred compensation gives you a significant tax break. In conventional savings, you pay taxes on income before you can set some aside for investing. Deferred compensation allows you to invest the full amount.

Conventional Savings Account

Total to invest	Taxes taken out	Total invested
$2,400	-$672	$1,728

(Assumes 28 percent tax bracket)

Deferred Compensation Account

Total to invest	Taxes taken out	Total invested
$2,400	-$0	$2,400

Second, your earnings also benefit from the tax deferral. And the advantage grows the longer you can invest in the plan. ***Examples shown here are illustrative and are NOT guaranteed.***

Assuming a $200 a month contribution, 5% interest, and a 28% pre-retirement tax bracket, your account balance with deferred compensation is much greater than conventional savings. After twenty years, your account balance with conventional savings would be approximately $57,138 compared to an estimated $79,358 with deferred compensation.

Does it matter when I begin savings?
Yes! It makes a huge difference. If you begin saving $100 biweekly today and earn an average of 5% annually, in 20 years you'll have $85,971 available. But if you wait five years to start, your account would have only $56,104. That's a $29,867 difference in your account. Compound earnings is most effective over longer periods. Waiting costs you money!

How much should I contribute?
You may want to consider putting away as much as you can afford for retirement, because every extra dollar you save will have an enormous impact over the long term. Say you are 30 years old and contribute $100 biweekly into your account. At age 60, if you earned 5% on your investment, you would have $172,741. But if you contributed just $25 more biweekly, you would have $215,926. A little extra goes a long way toward securing your retirement. This why you should save as much as you can for as long as you can.

HOW YOU INVEST

What are my investment options?
MissionSquare offers a wide array of mutual fund options, and these funds are subject to change. Information on available funds is found in the Plan's enrollment kit, on-line or by phone. See MissionSquare's contact information at the front of this booklet.

Periodically, MissionSquare representatives will be available to meet with plan participants to discuss investment options. The scheduling of these meetings is announced through the City's E- mail.

What are the fees, minimum investments, and/or restrictions? MissionSquare has a competitive fee structure and publishes all fees on-line through its Fee Disclosure Statement. The Retirement Board is responsible for plan oversight and reviews fees regularly. Based on information currently available, our fees are among the lowest in the industry. Attend a quarterly Board meeting to learn more.

You may generally transfer your assets between funds without restriction. However, some funds may limit your ability to conduct frequent transfers to protect the interest of other investors.

WITHDRAWING YOUR MONEY

When can I withdraw assets from my account?
During your employment, you can withdraw assets from your account only under strictly limited emergency conditions defined by IRS Rules and Regulations. **There is no loan provision.** You can withdraw funds only under the following conditions:

- Retirement – When you retire.
- Leaving employment of the City – When you leave your job for any reason.
- Unforeseeable emergency – This is defined as a severe financial hardship resulting from a sudden illness, disability or accidental property loss, subject to strict IRS guidelines.
- Small balance account withdrawals – You are eligible to initiate a one-time disbursement of your account if the balance is 75,000 or less and you have not contributed to the account for at least two years. Your account will automatically be distributed if the balance is less than $1,000 and no contributions have been made for two years.

After I leave employment with the City, what are my options? You may keep the money invested in the plan, transfer ("roll over") your money to another retirement plan, including another public employer's 457 plan, a qualified 401 plan, a 403(b) plan, or a Traditional IRA, or withdraw your assets. You have the ability to take your assets with you as you move between the public, private, and educational sectors.

Does MissionSquare offer an IRA?
Yes. MissionSquare offers a full-featured Vantagepoint IRA, including a brokerage option. These IRA's are outside of our payroll system and outside of our 457 Plan.

Does the 457 Plan offer a Roth Feature?
Yes, a Roth feature is offered as part of the 457 Plan, to which you may contribute on an after-tax basis. If your contributions remain in the plan for at least 5 years and you retire, you can make eligible withdrawals without having to pay income tax. The sum of regular 457 deferral contributions + Roth contributions cannot exceed the overall annual contribution maximum for 457 Plans.

When is the latest I must begin receiving benefits?
You must begin receiving benefit payments no later than April 1 of the calendar year following the year you reach age 73 beginning January 1, 2025, or the year in which you actually retire, if later.
This payment is called the Required Minimum Distribution.

When I retire, how do I schedule my benefit payments? MissionSquare provides you with numerous options. Election forms are available from Human Resources. You determine the payment schedule that's right for you from the following list:

A. Periodic payments (monthly, quarterly, etc.) over a specified number of years
B. Periodic payments (monthly, quarterly, etc.) over your determined life expectancy
C. Periodic payments of a specified amount per month or per year until the account is exhausted
D. Rollover to another plan or IRA
E. A lump-sum payment
F. Purchase of a lifetime annuity

Remember that withdrawals of funds not previously taxed will be subject to tax upon withdrawal at the tax rates in effect at that time.

What happens in the event of my death?
In the event of your death, the default payment schedule will generally be annual payments over a 10-year period. Your beneficiary should review the MissionSquare Beneficiary Withdrawal Packet for more information on options available. Your beneficiary may choose a shorter time frame. In most cases, these payments must begin by December 31 of the year following the year of your death. If your beneficiary is your spouse, he or she may roll the money into another retirement plan or IRA.

If you die after you started receiving benefits, your beneficiary should notify us as soon as possible so that your payment schedule can be halted while your beneficiary determines the schedule that will best suit his or her own financial needs.

Important Note:

The Plan information provided here is limited and does not include all information regarding the Plan. More complete information is available in the plan's enrollment kit book. Any discrepancy between the information contained herein and the Plan Document will be governed by the Plan Document.

If you do not select an investment fund, your contributions will be allocated to the Milestone Fund most appropriate for your age.

Retirement Health Savings (RHS) Plan

(Mandatory for All Eligible Employees)

INTRODUCTION

The City has contracted with MissionSquare (formerly ICMA) Retirement Corporation to offer the VantageCare Retirement Health Savings Plan (RHS). Participation in the Plan is mandatory for all employees in non-collectively bargained positions who have at least 1 year of regular service with the City as of July 1 of each calendar year. Effective January 1, 2010, participation in the Plan is mandatory for all employees in both the Police and the Fire collectively bargained units regardless of length of service.

Q1: What is the VantageCare RHS PLAN?

The RHS is the MissionSquare employer-sponsored, retirement health benefit savings vehicle that allows you to accumulate assets to pay for medical expenses (for example, health insurance and prescription expenses) in retirement on a tax-free basis.

The RHS is similar to the MissionSquare 401 and 457 plans offered through the City in that it allows you to invest dollars in the Vantagepoint Mutual Funds for needs during retirement. The RHS offers a number of benefits, including tax-deferred accumulation of income and tax-free withdrawals for the payment of eligible health care expenses that can exceed **$250,000** per retired couple.

Q2: What are the benefits of the VantageCare RHS Plan?

You can enjoy substantial benefits from the RHS Plan.

- **Convenience** – You only need to enroll (See Q3) when eligible and make decisions regarding investment of your RHS funds.
- **Allows payments for the following** – Eligible medical, dental and vision care expenses.

- **Tax-deferred accumulation of savings** – Assets grow in a tax-deferred account.
- **Tax-free withdrawals** – Withdrawals are tax-free when used for qualified medical expenses as defined under Section 213 of the Internal Revenue Code.
- **Investment options** – The RHS allows you to invest in a variety of mutual funds in different asset classes.
- **Flexibility** – You may use RHS dollars to pay medical, dental and vision expenses for yourself and your spouse and dependents following retirement.
- **Member Death** – Upon your death, your surviving spouse and surviving eligible dependents are immediately eligible to maintain the account and utilize it to fund eligible medical benefits. If you have no surviving spouse or eligible dependents, your balance reverts to the Plan.

Q3: How do I get started?

1. The City will provide you with enrollment material when you are hired.
2. You complete the enrollment form and return it to the Human Resources Department. This form includes participant indicative data (e.g. name and address) and spouse/dependent information.
3. When you become eligible, your participant data will be sent to MissionSquare.
4. MissionSquare will set up your account.
5. MissionSquare will send you a welcome letter
6. You can make changes to the account, including investment allocation, on-line or by speaking to a MissionSquare Customer Services associate. Information on how to contact MissionSquare will be included in the enrollment materials sent to new participants.

Q4: Can I opt out of the VantageCare RHS?

No, all eligible employees must participate as a condition of employment. But once you are familiar with the benefits of the program, you won't want to opt out. RHS provides you with a tax- free way to pay for your medical expenses in retirement, which are now estimated to be $400,000 per retired couple.

Q5: What contributions will be made to my VantageCare RHS?

There are three types of contributions allowed to the Plan per IRS guidelines: employer or City contributions, employee contributions and contributions based on unused sick leave.

Direct Employer (City) Contributions:

Collectively Bargained Police and Fire Positions – Each pay period the City and employee will contribute an amount according to the Police and Fire CBA Agreement in place.

Non-Collectively Bargained Positions - If available, annual funding from the City will distribute a flat dollar amount to all eligible employees based on their employment status on July 1 of each calendar year. Normal funding levels for previous years were $400 for full-time employees, $300 for three- quarter time employees and $200 for half-time employees. Funding and funding levels will be reviewed annually with approved contributions made in July of each calendar year.

Direct Employee Contributions:

Collectively Bargained Police and Fire Positions – Each pay period the employee will contribute an amount equal to 1% of their earnings to their RHS account.

Unused Leave (employee) Contributions: In addition to City funding, and employee funding for collectively bargained positions, your RHS account will be funded with unused sick leave contributions on both an ongoing basis and at time of separation or retirement. Such contributions will be based on the following:

For Participants who are active employees and not working as shift personnel in the fire department on the first day of each calendar year and who have in excess of 480 hours of accumulated sick leave as of that date.

Each year the City will convert all such excess hours, up to a maximum of 40 hours, to their cash equivalent by multiplying one- half (1/2) of those hours in excess of 480 times the employee's hourly rate of pay on the last pay period of the previous year. An amount equal to the cash equivalent will then be contributed to the employee's individual retiree savings account. By way of example, for such employee paid at the hourly rate of $10.00 per hour with 500 hours of accumulated sick leave on January 1, a contribution of $100.00 will be made to the employee's account. (500 hours minus 480 hours = 20 hours in excess of 480 hours times 1/2 =10 hours x $10 =$100.00).

For Participants who are active employees working as shift in the fire department on the first day of each calendar year and who have in excess of 672 hours of accumulated sick leave as of that date.

Each year the City will convert all such excess hours, up to a maximum of 56 hours, to their cash equivalent by multiplying one- half (1/2) of those hours in excess of 672 times the employee's hourly rate of pay on the last pay period of the previous year. An amount equal to the cash equivalent will then be contributed to the employee's individual retiree savings account. By way of example, for such employee paid at the hourly rate of $10.00 per hour with 700 hours of accumulated sick leave on January 1, a contribution of $140.00 will be made to the employee's account. (700 hours minus 672 hours = 28 hours in excess of 672 hours times 1/2 =14 hours x
$10 =$140.00).

For Participants who separate or retire on or after January 1, 2003 and who have any amount of accumulated sick leave at the time of separation or retirement.

The City will convert 100% of the cash-out value of such accumulated sick leave (as determined by Longmont Municipal Code section 3.04.720) to its cash equivalent by multiplying one- half (1/2) of the total accumulated sick leave times the employee's current hourly rate of pay. Such cash equivalent will then be contributed to the employee's individual retiree savings account.
By way of example, for an employee paid at the hourly rate of
$10.00 per hour with a total of 400 hours of accumulated sick leave, a contribution of $2,000.00 will be made to the employee's account. (400 hours times 1/2 = 200 hours times $10 = $2,000.00).

Q6: Where will my RHS assets be invested?

The Plan makes available to you a wide range of mutual fund investments. Upon initial enrollment in the RHS Plan, your investment allocation is automatically established as the Vantagepoint Milestone Fund. However, you may change the investment allocation for future contributions or move current funds at any time through MissionSquare's toll free automated service line, the MissionSquare web site, or a MissionSquare Customer Service representative.

If you should die while participating in the RHS Plan, your account balance will automatically become 100% vested. Your spouse/dependents may transfer the account balance into the investments of their choice within the Plan.

Q7: What are the benefits?

You may be reimbursed for qualifying medical, dental and vision expenses as defined by the IRS in IRS Publication 502, *Medical and Dental Expenses*. This same information can be found on-line at http://www.irs.gov.

Note that your RHS account can also be used to pay for medical expenses of your legal spouse and eligible dependents.

Should you die, your surviving spouse/dependents can continue to use the account for medical expenses (Account Transfer).

Q8: Who are my dependents?

Your spouse and dependent children are your dependents under the plan.

Q9: When May I Receive Benefits? When am I vested?

You may begin receiving benefits at any time after separating or retiring from the City and turning age 50. At that time you need to contact the City and complete a *VantageCare Retiree Health Savings Plan Employee Benefit Eligibility Form*, available from the City's Human Resources Department. Full vesting to City contributions occurs once you complete three years of eligible service.

Q10: Who will pay medical benefit claims?

Medical benefit claims payment and administration will be handled by Meritain Health, Inc., a third-party claims administrator hired by MissionSquare.

All questions regarding claims should be directed to Meritain Health at 1-888-587-9441. Claims representatives are available from 9:30 a.m. to 5:30 p.m. Eastern Time.

Q11: How do I submit a claim for medical reimbursement?

Claims for medical expenses that qualify for reimbursement (see Q7) are submitted for reimbursement to Meritain Health, Inc. on the *VantageCare Retiree Health Savings Plan Benefits Reimbursement Request Form*, available from MissionSquare or the City's Human Resources Department.

Q12: What if a claim is denied?

If your claim for medical benefits is denied, you will receive a written notice of the denial from Meritain Health, Inc. The notice will include:

- The specific reason(s) for the denial;
- Reference to Plan rules upon which the denial was based;
- Description of any additional information that might be required and an explanation of why it is needed; and
- An explanation of the Plan's claim review procedure.

You may appeal a denied claim. If you wish to appeal a claim you should contact Meritain Health, Inc. or the City's Human Resources Department for details.

Q13: What happens to my vested account balance if I leave my job before I am eligible for benefits?

If you leave employment with the City prior to becoming eligible for medical benefits, your account balance will remain with the plan and continue to accrue tax-deferred earnings until you reach eligibility at age 50.

Q14: When I leave my job with the City, can I roll my RHS account balance into an IRA?

No. Your RHS account must remain in the City's RHS Plan. Currently, the IRS does not allow these funds to be rolled into any other type of plan, including an IRA.

Q15: How are RHS benefits treated for tax purposes?

RHS benefits paid in the form of medical expense reimbursements are not currently taxable. No income tax withholding or reporting is required, and you do not need to report any medical benefits at all on your income tax return.

Q16: How do I make changes to my account?

Changes to your name or address should be made through the Human Resources Department who will notify all affected providers.

After you become eligible for medical benefits, changes to your account information should also be communicated to Meritain Health, Inc. at 1-888-587-9441.

Investment allocation changes for future contributions and fund-to- fund transfers of existing account balances can be made by phone, the web site, or a MissionSquare Customer Services representative.

Q17: What types of reports will I receive?

You will receive Summary Plan Statements on a quarterly and annual basis. The Summary Plan Statements will provide information on contributions, investment earnings, and distributions. The statements will use the same format as the MissionSquare 401/457

You will also receive confirmations of benefit payments, address changes, investment allocation changes, and fund-to-fund transfers. Reports are available on-line at www.missionsq.org.

Q18: Whom should I contact with questions regarding my RHS account?

The City:
Determines program parameters, enrollment and benefit eligibility and is responsible for submitting contributions to your account. For all other information, please contact either Meritain Health, Inc. or MissionSquare.

Meritain Health, Inc.
(1-888-587-9441; Fax 1-888-665-8495):
Handles all claim related issues once you are eligible to receive benefits.

MissionSquare (1-800-669-7400):
Handles all non-claim related issues pertaining to your account: such as receiving contributions and allocating funds to investment vehicles and maintaining records of account balances.

Important Note:

The Plan information provided here is limited and does not include all information regarding the Plan. More complete information on the Plan may be obtained directly from MissionSquare. Any discrepancy between the information contained herein and the Plan Document will be governed by MissionSquare and the Plan Document.

If you do not select and investment fund through MissionSquare, your contributions will be deposited into the Milestone Fund most appropriate for your age.

Paid and Unpaid Leaves of Absence

HOLIDAY LEAVE

The City provides the following eleven paid holidays each year to regular benefit eligible non-shift employees:

New Year's Day	January 1
Martin Luther King, Jr. Day	3rd Monday in January
President's Day	3rd Monday in February
Memorial Day	Last Monday in May
Juneteenth	June 19
Independence Day	July 4
Labor Day	1st Monday in September
Veteran's Day	November 11
Thanksgiving	4th Thursday in November
Day after Thanksgiving	4th Friday in November
Christmas Day	December 25

Eight hours of additional leave are designated as a floating holiday. These hours must be taken during each calendar year and cannot be carried into another year. City offices will not be closed for these additional eight hours. Holidays falling on Saturday or Sunday will be observed respectively on Friday or Monday.

Shift employees who are required to work on City designated holidays will accrue combined holiday/vacation leave.

VACATION LEAVE – See Personnel Rules

SICK LEAVE

Sick leave is a benefit given to City employees in order to protect their earning capabilities in the event of an illness or injury. Paid sick leave will be authorized for sickness, injury, hospitalization, family illness, and medical or dental appointments, birth and adoption.

Sick leave is accumulated at the rate of eight hours per month for regular full-time employees (11.2 hours per month for shift fire employees) and may be continuously accumulated for use in the event of illness. In addition, a maximum of 960 hours of sick leave (1344 for shift fire employees) will either paid out or contributed to your Retiree Health Savings (RHS) Plan account at time of retirement or termination. If you are a member of the RHS Plan, then all unused sick leave at time of retirement or termination will be contributed to your RHS account. If you are not a member of the RHS Plan, then all of your unused sick leave will be paid out to you. Any sick leave hours that are paid out or contributed to your RHS account at time of separation are paid at the rate of one hour's pay for every two hours of accumulated sick leave.

SICK LEAVE CONVERSION

Beginning January 2002 (and every January thereafter), the City will identify all regular employees other than shift personnel in the fire department, who have accumulated in excess of four hundred eighty hours of sick leave, and all shift personnel in the fire department who have accumulated in excess of six hundred seventy-two hours of sick leave. The City will convert to a cash equivalent and pay to the employee's individual Retiree Health Savings account the first fifty-six hours of excess sick leave earned but unused during the prior calendar year for shift personnel in the fire department and the first forty hours of excess sick leave earned but unused during the prior calendar year for all other regular employees.

Unused excess sick leave earned during the prior calendar year and not converted and contributed to the employee's individual Retiree Health Savings account is eligible for conversion either to vacation days or to a cash payment at the employee's option.

Conversion for all purposes shall be at the rate of one hour for every two hours accumulated, i.e., each day of sick leave eligible for conversion to vacation, cash or transfer to the individual Retiree Health Saving account equals one-half day of vacation, or one-half day of pay at the employee's hourly rate of pay as of the last pay date of the prior calendar year.

FAMILY AND MEDICAL LEAVE

Family and Medical Leave is a period of unpaid leave during, which the employee will retain his or her position and status as an employee of the City. Available accruals may be run concurrently, subject to the terms of use specified for each type in the Personnel Rules. To be eligible for Family and Medical Leave, an employee must have been employed by the City at least one year and worked a minimum of 1,250 hours during the 12-month period immediately preceding the leave. Medical, dental and vision insurance is available at the same premium rate as when on a paid employment status. If the employee wishes to retain other benefit coverage, he or she can do so by contacting the Human Resources Department and making arrangements to pay the required premiums.

Employees who have a serious health condition, have a child, spouse or parent with a serious health condition, or are requesting leave for reasons of pregnancy, birth of a child, or placement for foster care or adoption, are eligible for Family and Medical Leave in the amount of up to 12 weeks within a 12-month period. Eligible employees must provide medical certification to support a request for leave because of a serious health condition. If the leave is foreseeable, employees must provide 30 days advance notice. An employee will not accumulate additional leave during unpaid Family Medical Leave.

Family and Medical Leave also includes provisions related to qualifying instances arising from a spouse, child or parent being an active military member on covered active duty or call to covered active duty, as well as the need to care for a covered active duty

service member with a serious illness or injury. In the case of injury or illness of an active-duty service member, next of kin situations also apply.

PARENTAL AND CAREGIVER LEAVE

Any regular benefited employee who meets eligibility may request up to six weeks of paid parental leave following the birth of an employee's child or the placement of a child with an employee in connection with adoption or foster care. In addition, up to six weeks of paid caregiver leave may be requested for the following circumstances: To care for individuals who have served in an immediate parental role for the individual, and to care for a spouse or child with a serious health condition. This policy will run concurrently with Family Medical Leave Act (FMLA) leave as applicable. Parental and caregiver leave is limited to three instances within an employee's lifetime. Further information is available in the Personal Rules, Sec. 3.04.810.

BEREAVEMENT LEAVE

Regular and part-time non-benefited employees have available paid leave of up to one work week in the event of the death of a member of their immediate family. For purposes of Bereavement Leave, immediate family includes the employee's spouse, child, grandchild, brother or sister, parent, father-in-law, mother-in-law, grandfather, grandmother, stepparent, stepbrother, stepsister, stepchild and any other relatives regularly residing in the employee's home.

JURY AND WITNESS LEAVE

An employee will be given time off with pay for their regularly scheduled work hours when performing jury duty in a municipal, county, state, or federal court, or when required to serve as a subpoenaed third-party witness. Paid leave is given provided the employee reimburses the City any jury or witness fees received, excluding mileage and parking reimbursement. A plaintiff or defendant in a personal case not as result of his or her official capacity will not be granted jury leave.

MILITARY LEAVE

Any regular employee serving in the Military Reserves or Emergency National Guard will be entitled to 30 calendar days of military leave, provided they reimburse the City any compensation received from the military.

LEAVE WITHOUT PAY

For the good of the City and at an employee's request, the City Manager may grant a period of Leave without Pay to any regular employee for a period of time not to exceed one year.

LEAVE SHARING

A Direct Donation Leave Sharing program allows employees to voluntarily donate accrued sick and/or vacation leave to other employees who have a serious health condition, are caring for a child after birth, adoption or foster care placement, or are providing support for a child, spouse or parent with a serious health condition. The program is intended to provide some income protection for employees who must be absent from work for an extended period of time and have exhausted all forms of paid leave. Further information is available in the Administrative Regulation.

Required Annual Disclosure Notices

The following notices are provided annually, as required by federal regulation.

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights

City of Longmont is committed to the privacy of your health information. The administrators of the City of Longmont Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Joanne Zeas - Chief HR Officer at 303.651.8605 or joanne.zeas@longmontcolorado.gov.

HIPAA SPECIAL ENROLLMENT

City of Longmont Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the City of Longmont Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for

adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Joanne Zeas - Chief HR Officer at 303.651.8605 or joanne.zeas@longmontcolorado.gov.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

PATIENT PROTECTIONS DISCLOSURE

The City of Longmont Health Plan generally allows 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, Kaiser Permanente designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Kaiser Permanente at 855.249.5005 or www.kp.com.

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

You do not need prior authorization from Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Kaiser Permanente at 855.249.5005 or www.kp.com.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1—CITY OF LONGMONT HMO 2025 PLAN:

Individual: 10% coinsurance and $250 deductible; Family: 10% coinsurance and $500 deductible

Plan 2—CITY OF LONGMONT CHOICE PPO PLAN:
In-Network: Individual: 10% coinsurance and $250 deductible; Family: 10% coinsurance and $500 deductible;

Out-of-Network: Individual: 50% coinsurance and $2,000 deductible; Family: 50% coinsurance and $4,000 deductible

If you would like more information on WHCRA benefits, please call your Plan Administrator at 303.651.8605 or joanne.zeas@longmontcolorado.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 or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	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	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Services
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)
U.S. Department of Health and Human
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

COBRA GENERAL NOTICE
Continuation Coverage Rights Under COBRA

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under 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 get 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 a 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 under 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 doesn't 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're an employee, you'll become a qualified beneficiary if you lose your 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're the spouse of an employee, you'll 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 his or her 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 hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her 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 that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Joanne Zeas.

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 coverage on behalf of their 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.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 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. The disability would have to have started at 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.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation 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 getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under 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 dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, 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/**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

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 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

[1]https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

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

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.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.

Plan contact information

City of Longmont
Joanne Zeas - Chief HR Officer
350 Kimbark St
Longmont, Colorado 80501-5500
303.651.8605

NOTICE OF CREDITABLE COVERAGE
Important Notice from City of Longmont About
Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Longmont and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **City of Longmont has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

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

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Longmont coverage will not be affected. The City's plan will continue to be primary payer of prescription drug benefits and Medicare will continue to be secondary payer of drug benefits.

If you decide to join a Medicare drug plan and drop your current City of Longmont coverage, be aware that you and your dependents will be able to get this coverage back only if you continue in active employment and re-enroll for City of Longmont coverage at the next Open Enrollment.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Longmont and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage…

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

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

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	**January 1, 2025**
Name of Entity/Sender:	**City of Longmont**
Contact—Position/Office:	**Joanne Zeas - Chief HR Officer**
Office Address:	**350 Kimbark St, Longmont, Colorado 80501-5500**
Phone Number:	**303.651.8605**

CITY OF LONGMONT GROUP HEALTH PLAN NOTICE OF PRIVACY PRACTICES

THIS NOTICE IS EFFECTIVE SEPTEMBER 23, 2013, AND DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The City of Longmont group health plan is required by law to maintain the privacy of "protected health information."

"Protected health information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care.

As required by law, this notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of protected health information. This notice also discusses the uses and disclosures the City of Longmont group health plan will make of your protected health information.

The City of Longmont group health plan reserves the right to change the terms of this notice from time to time and to make the revised notice effective for all protected health information we maintain. You can always request a copy of our most current privacy notice from our office, or you can access it on our Web site.

PERMITTED USES AND DISCLOSURES

The City of Longmont group health plan can use or disclose your protected health information for purposes of treatment, payment and health care operations.

Treatment means the provision, coordination or management of your health care, including referrals for health care from one health care provider to another. For example, a provider under the City of Longmont group health plan may need to know health care information in plan files that might assist in treatment.

Payment means activities to obtain and provide reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities. For example, the information on or accompanying health care bills sent to the plan may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

As another example, prior to providing health care services, the City of Longmont group health may need information from a provider about your medical condition to determine whether the proposed course of treatment will be covered. When the plan receives a bill from the provider, the City of Longmont group health can obtain information regarding your care if necessary to provide payment.

Health care operations means the support functions related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities. For example, we may use your medical information to evaluate the performance of providers used in our plan. We may also combine medical information about many patients to decide how to better provide needed benefits under the plan.

OTHER USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The City of Longmont group health plan may contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you.

The City of Longmont group health plan may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care.

The City of Longmont group health plan will only disclose the protected health information directly relevant to their involvement in your care or payment. The City of Longmont group health plan may also use or disclose your protected health information to notify, or assist in the notification of, a family member, a personal representative, or another person responsible for your care of your location, general condition, or death. If you are available, the City of Longmont group health plan will give you an opportunity to object to these disclosures, and the plan will not make these disclosures if you object. If you are not available, the City of Longmont group health plan will determine whether a disclosure to your family or friends is in your best interest, and the plan will disclose only the protected health information that is directly relevant to their involvement in your care. When permitted by law, the City of Longmont group health plan may coordinate our uses and disclosures of protected health information with public or private entities authorized by law or by charter to assist in disaster relief efforts.

Except for the situations set forth below, the City of Longmont group health plan will not use or disclose your protected health information for any other purpose unless you provide written authorization.

You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that the City of Longmont group health plan already has taken action in reliance on your authorization.

EXCEPTIONAL SITUATIONS

We may use or disclose your protected health information in the following situations without your authorization:

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

Health Oversight Activities. We may disclose medical information to federal or state agencies that oversee our activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws. We may disclose protected health information to persons under the Food and Drug Administration's jurisdiction to track products or to conduct post-marketing surveillance.

Inmates. If you become an inmate of a correctional institution or fall under the custody of a law enforcement official, the plan may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

Law Enforcement. We may release medical information in these situations: if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime; the location of the crime or victims or the identity, description or location of the person who committed the crime.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, or other national security activities authorized by law.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of product, recalls, repairs or replacements; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Serious Threats. As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Workers' Compensation. We may release medical information about you for programs that provide benefits for work-related injuries or illness.

YOUR RIGHTS

- You have the right to request restrictions on the City of Longmont group health plan's uses and disclosures of protected health information for treatment, payment and health care operations. However, the City of Longmont group health plan is not required to agree to your request.
- You have the right to reasonably request to receive communications of protected health information by alternative means or at alternative locations.
- Subject to payment of a reasonable copying charge (if you cannot afford to pay for copies, you will not be denied access), you have the right to inspect and copy the protected health information contained in the plan's records, except for psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed.
- You have the right to request a correction to your protected health information, but the City of Longmont group health plan may deny your request for correction. Any agreed upon correction will be included as an addition to, and not a replacement of, already existing records.
    - You have the right to receive an accounting of disclosures of protected health information made by the plan to individuals or entities other than to you, except for disclosures to carry out treatment, payment and health care operations as provided above; to persons involved in your care or for other notification purposes as provided by law; for national security or intelligence purposes as provided by law; to correctional institutions or law enforcement officials as provided by law; or that occurred prior to April 14, 2003.
- You have the right to request and receive a paper copy of this notice from us.

FILING A COMPLAINT - If you believe that your privacy rights have been violated, you should immediately contact our Privacy Officer at 303-651-8606. The City of Longmont group health plan will not take action against you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

CONTACT PERSON - If you have any questions or would like further information about this notice, please contact The City's Benefits Administrator and Privacy Officer at 303-651-8606.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR COVERAGE

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace (“Marketplace”). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn’t meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee’s household income.[1] [2]

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the “minimum value standard,” the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either-submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Joanne Zeas, Chief Human Resources Officer, at 303.651.8605.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
City of Longmont		84-6000608
5. Employer address		6. Employer phone number
350 Kimbark St		303.651.8605
7. City	8. State	9. ZIP code
Longmont	CO	80501
10. Who can we contact about employee health coverage at this job?		
Joanne Zeas, Chief HR Officer		
11. Phone number (if different from above)	12. Email address	
	joanne.zeas@longmontcolorado.gov	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ✓ All employees. Eligible employees are: Full-time employees who work at least 20 hours per week.
  - ☐ Some employees.
- With respect to dependents:
  - ✓ We do offer coverage. Eligible dependents are: Your spouse, your children under age 26, and your disabled dependents of any age.
  - ☐ We do not offer coverage.
- ✓ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13.	**Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?** ☐ **Yes** (Continue) 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue) ☐ **No** (STOP and return this form to employee)
14.	Does the employer offer a health plan that meets the minimum value standard*? ☐ Yes (Go to question 15) ☐ No (STOP and return form to employee

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

15. For the lowest cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan?

b. How often? □ Weekly □ Every 2 weeks □ Twice a month □ Monthly □ Quarterly □ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

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16. What change will the employer make for the new plan year?

□ Employer won't offer health coverage

□ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard. * (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? □ Weekly □ Every 2 weeks □ Twice a month □ Monthly □ Quarterly □ Yearly

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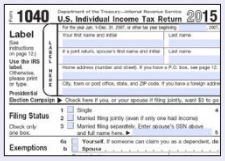
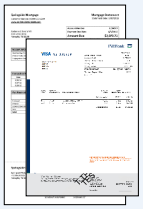
CITY OF LONGMONT
VERIFICATION DOCUMENTS

Dependent Category	Documents Required to Complete Dependent Verification
Biological Child	**Birth Certificate** is required for each biological child 6 months old or older. The birth certificate must be issued by the state, county, or other government body AND list the employee as a parent. Note: A short form birth certificate, which does not list the parents of the child, is not suitable for this dependent verification. **OR** **Hospital Letter**—If birth certificate is not available for a child under 6 months old, submit birth documentation on hospital letterhead indicating the birth date of the child or children, AND the names of the parent(s). **OR** **Court Order**—If birth certificate is not available, a court order (such as a Qualified Medical Child Support Order, National Medical Support Notice or other court document) may be substituted.
Adopted Child	**Placement Papers OR Adoption Agreement OR Birth Certificate**— Send a copy of the placement papers for a child placed with you for adoption (initial stage), or Official Court Adoption Agreement for an adopted child (mid-stage), or legal birth certificate (final stage). **OR** **Court Order**—If birth certificate is not available, a court order (such as a Qualified Medical Child Support Order, National Medical Support Notice or other court document) may be substituted.
Stepchild	**Child's Birth Certificate**— Send a copy of the child's government-issued birth certificate showing that the child's parent is the employee's spouse. **AND** **Legal Marriage or Common Law Marriage Documents**—See notes in the Legal Marriage or Common Law Marriage section for information about submitting these documents.
Other Child Type	For a grandchild, niece/nephew, brother/sister, or other child type, send guardianship papers. **Guardianship Papers**—Court papers demonstrating legal guardianship. Document must include the name(s) of the person(s) designated as the legal guardian(s).
Disabled Child, Over Age 26	**Disabled Child**—Send a copy EITHER the child's latest SSDI award letter, or physician's statement of disability. Either statement must not be dated more than 18 months ago.

CITY OF LONGMONT
VERIFICATION DOCUMENTS

<table>
<tr><th>Dependent Category</th><th colspan="2">Documents Required to Complete Dependent Verification</th></tr>
<tr><td>Legal Marriage (Opposite Sex or Same Sex)

Marriages in past 12 months: Send the Legal Marriage Certificate only.</td><td>Option 1
Legal Marriage Certificate
AND Two Joint Financial Documents
  & 
Send a copy of your <u>legal marriage certificate</u> AND
Send a copy of <u>two current joint financial documents showing you and your spouse at the same address.</u>
• Examples of joint financial documents include: mortgage statement, joint homeowners or renters insurance declaration page, auto insurance policy declaration page, auto loan, personal loan, credit card, and utility bill (except mobile phone bills).
• Documents must be dated within the past 60 days.
• Documents must be from two different organizations (for example, do not send a credit card statement and auto loan statement from the same bank).</td><td>Option 2
Most recent 1040
Tax Form
 
Send a copy of the <u>first page of your 1040 federal income tax return showing a married filing status</u>.
• If you file separately, send the first page of both your and your spouse's federal income tax return.
• Do not send W-2s.</td></tr>
<tr><td>Common Law Marriage</td><td>Option 1
Colorado Affidavit of Common Law Marriage AND
Two Joint Financial Documents
  & 
Send a copy of your <u>Colorado Affidavit of Common Law Marriage</u> AND
Send a copy of <u>two current joint financial documents showing you and your spouse at the same address</u>.
• Examples of joint financial documents include: mortgage statement, joint homeowners or renters insurance declaration page, auto insurance policy declaration page, auto loan, personal loan, credit card, and utility bill (except mobile phone bills).
• Documents must be dated within the past 60 days.
• Documents must be from two different organizations (for example, do not send a credit card statement and auto loan statement from the same bank).</td><td>Option 2
Most Recent 1040
Tax Form
Send a copy of the <u>first page of your 1040 federal income tax return showing a married filing status</u>.
• If you file separately, send the first page of both your & your spouse's federal income tax return.
• Do not send W-2s.</td></tr>
<tr><td>Legally Separated</td><td colspan="2"><u>Legal Separation Agreement</u>
• Send a copy of the legal separation agreement on file with the court. If this document is not available, please submit a letter of explanation.</td></tr>
<tr><td>Divorced</td><td colspan="2"><u>Final Divorce Decree</u>
• Send a copy of the final divorce decree on file with the court.</td></tr>
</table>

2025 RETIREMENT PLANS
For General Benefited Employees

PLAN TYPE	MANDATORY EMPLOYEE CONTRIBUTION	CITY CONTRIBUTION	ADDITIONAL VOLUNTARY CONTRIBUTION	VESTING PERIOD	RECORDKEEPER
MOPC - Money Accumulation Plan					
401(a) - you select investments from a menu of choices	• 5% of salary if hired on or before 12/31/11 (pretax) • 6% of salary if hired on or after 1/1/12 (pretax)	5% of salary	No specific limit on voluntary, after-tax contributions. *Total* annual contributions from all sources can't exceed the lesser of $70,000 or 100% of compensation.	Vesting in City contribution: • Less than 1 year - 0% • 1 year - 25% • 2 years - 50% • 3 years - 100%	Empower Retirement
GERP - General Employees' Retirement Plan					
Defined Benefit - pays a monthly benefit based on final average salary and years of service	• 7.0% if hired on or before 12/31/11 (pretax) • 6.0% of salary if hired on or after 1/1/12 (pretax)	Actuarially determined amount necessary to fund the benefit, Currently 9.4%	None	Vesting in City contribution: • Less than 5 years - 0% • 5 years - 100%	N/A
Retirement Health Savings Plan					
You select investments from a menu of choices. General employees with at least one year of service as of July 1 are eligible.	None	• Full time - $400/year • 3/4 time - $300/year • 1/2 time - $200/year	None	• Less than 3 years - 0% • 3 years - 100%	MissionSquare
457 Plan (optional)					
Deferred Compensation -you select investments from a menu of choices (pretax and Roth options available). Email tiffinie.gaibler@longmont.gov for enrollment information or to get started.	N/A	N/A	Up to the annual IRS limit -Currently $23,500 -Age 50 & Over Catch Up; up to an additional $7,500 -Age 60 - 63 Super Catch Up; up to an additional $11,250	N/A	MissionSquare

12/05/24

2025 RETIREMENT PLANS
Sworn Fire Employees

PLAN TYPE	MANDATORY EMPLOYEE CONTRIBUTION	CITY CONTRIBUTION	ADDITIONAL VOLUNTARY CONTRIBUTION	VESTING PERIOD	RECORDKEEPER
FPPA - FOR SWORN FIRE EMPLOYEES hired after 11/09/21					
Defined Benefit - see FPPA materials for details or visit *FPPAco.org*	12% of salary	10.5% of salary	No specific limit on voluntary, after-tax contributions. Total annual contributions from all sources can't exceed the lesser of $70,000 or 100% of compensation	Vesting in City contribution: • Less than 5 years - 0% • 5 years - 100%	N/A
FPPA - FOR SWORN FIRE EMPLOYEES (re-entry employees who exited the new hire plans)					
Three plan options. See FPPA materials for details or visit *FPPAco.org*	DB 12.1% Hybrid 12.1% Hybrid MP 12.1%	• Defined benefit - 10.6% • Hybrid - 12.1% • Hybrid MP - 12.1%	No specific limit on voluntary, after-tax contributions. Total annual contributions from all sources can't exceed the lesser of $70,000 or 100% of compensation	All participants became fully vested at the time of transfer to FPPA.	Fidelity Investments
New Hire Plans - FOR SWORN FIRE EMPLOYEES hired before 11/10/21 (closed to new participants)					
401(a) - you select investments from a menu of choices	12% of salary	12.1 % of salary	No specific limit on voluntary, after-tax contributions. *Total* annual contributions from all sources can't exceed the lesser of $70,000 or 100% of compensation.	Vesting in City contribution: • Less than 3 years - 0% • 3 years - 60% • 4 years - 80% • 5 years - 100%	MIssionSquare
Retirement Health Savings Plan - FOR ALL SWORN FIRE EMPLOYEES					
You select investments from a menu of choices. Uniformed Police and Fire staff are eligible upon employment.	0-9.99 Years of Service (YOS) - 1.5% of salary 10-19.99 YOS - 1.75% of salary 20 or > YOS - 2.0% of salary	Same as employee contributions plus milestone & catch-up contributions per 2025 CBA agreement	N/A	Vesting in City contribution: • Less than 3 years - 0% • 3 years - 100%	MissionSquare
457 Plan (mandatory)- FOR ALL SWORN FIRE EMPLOYEES					
Deferred Compensation -you select investments from a menu of choices (pretax and Roth options available). Email tiffinie.gaibler@longmont.gov for enrollment information or to get started.	.50% of salary	.50% of salary	Up to the annual IRS limit -Currently $23,500 -Age 50 & Over Catch Up; up to an additional $7,500 -Age 60 - 63 Super Catch Up; up to an additional$11,250	N/A	MissionSquare

12/06/24

2025 RETIREMENT PLANS

Non Sworn Collectively Bargained PS Employees

PLAN TYPE	MANDATORY EMPLOYEE CONTRIBUTION	CITY CONTRIBUTION	ADDITIONAL VOLUNTARY CONTRIBUTION	VESTING PERIOD	RECORDKEEPER
MOPC - Money Accumulation Plan					
401(a) - you select investments from a menu of choices	• 5% of salary if hired on or before 12/31/11 (pretax) • 6% of salary if hired on or after 1/1/12 (pretax)	5% of salary	No specific limit on voluntary, after-tax contributions. *Total* annual contributions from all sources can't exceed the lesser of $70,000 or 100% of compensation.	Vesting in City contribution: • Less than 1 year - 0% • 1 year - 25% • 2 years - 50% • 3 years - 100%	Empower Retirement
GERP - General Employees' Retirement Plan					
Defined Benefit - pays a monthly benefit based on final average salary and years of service	• 7.0% if hired on or before 12/31/11 (pretax) • 6.0% of salary if hired on or after 1/1/12 (pretax)	Actuarially determined amount necessary to fund the benefit, Currently 9.4%	None	Vesting in City contribution: • Less than 5 years - 0% • 5 years - 100%	N/A
Retirement Health Savings Plan					
You select investments from a menu of choices. General employees with at least one year of service as of July 1 are eligible.	1%	1%	None	• Less than 3 years - 0% • 3 years - 100%	MissionSquare
457 Plan (optional)					
Deferred Compensation -you select investments from a menu of choices (pretax and Roth options available). Email tiffinie.gaibler@longmont.gov for enrollment information or to get started.	N/A	N/A	Up to the annual IRS limit -Currently $23,500 -Age 50 & Over Catch Up; up to an additional $7,500 -Age 60 - 63 Super Catch Up; up to an additional $11,250	N/A	MissionSquare

12/05/24

2025 RETIREMENT PLANS
Sworn Police Employees

PLAN TYPE	MANDATORY EMPLOYEE CONTRIBUTION	CITY CONTRIBUTION	ADDITIONAL VOLUNTARY CONTRIBUTION	VESTING PERIOD	RECORDKEEPER
FPPA - FOR SWORN POLICE EMPLOYEES hired after 11/09/21					
Defined Benefit - see FPPA materials for details or visit *FPPAco.org*	12% of salary	10.5% of salary	No specific limit on voluntary, after-tax contributions. Total annual contributions from all sources can't exceed the lesser of $70,000 or 100% of compensation	Vesting in City contribution: • Less than 5 years - 0% • 5 years - 100%	N/A
FPPA - FOR SWORN POLICE EMPLOYEES (re-entry employees who exited the new hire plans)					
Three plan options. See FPPA materials for details or visit *FPPAco.org*	Defined Benefit - 12.1% Hybrid 12.1% Hybrid MP 12.1%	• Defined benefit - 10.6% • Hybrid - 12.1% • Hybrid MP - 12.1%	No specific limit on voluntary, after-tax contributions. Total annual contributions from all sources can't exceed the lesser of $70,000 or 100% of compensation	All participants became fully vested at the time of transfer to FPPA.	Fidelity Investments
New Hire Plans - FOR SWORN POLICE EMPLOYEES hired before 11/10/21 (closed to new participants)					
401(a) - you select investments from a menu of choices	12% of salary	12.1% of salary	No specific limit on voluntary, after-tax contributions. *Total* annual contributions from all sources can't exceed the lesser of $70,000 or 100% of compensation.	Vesting in City contribution: • Less than 3 years - 0% • 3 years - 60% • 4 years - 80% • 5 years - 100%	MIssionSquare
Retirement Health Savings Plan - FOR ALL SWORN POLICE EMPLOYEES					
You select investments from a menu of choices. Uniformed Police and Fire staff are eligible upon employment.	0-9.99 Years of Service (YOS) - 1.5% of salary 10-19.99 YOS - 1.75% of salary 20 or > YOS - 2.0% of salary	Same as employee contributions plus milestone & catch-up contributions per 2025 CBA agreement	N/A	Vesting in City contribution: • Less than 3 years - 0% • 3 years - 100%	MissionSquare
457 Plan (optional)- FOR ALL SWORN POLICE EMPLOYEES					
Deferred Compensation -you select investments from a menu of choices (pretax and Roth options available). Email tiffinie.gaibler@longmont.gov for enrollment information or to get started.	N/A	N/A	Up to the annual IRS limit -Currently $23,500 -Age 50 & Over Catch Up; up to an additional $7,500 -Age 60 - 63 Super Catch Up; up to an additional $11,250	N/A	MissionSquare

12/06/24