



City of Pasadena

2026 Benefits Guide



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This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Contact List

BENEFIT	VENDOR	GROUP #	PHONE #	WEB
Medical & Prescription Drugs	UnitedHealthcare	909727	Broad – 866.844.4864 Charter – 877.805.1970 Nexus – 888.331.3408	www.myuhc.com
Dental	Humana	420382	800.233.4013	www.myhumana.com
Vision	Community Eye Care	CTYPASAD01	888.254.4290	https://www.cecvision.com
Flexible Spending Account	WEX	28985	866.451.3399	https://benefitslogin.wexhealth.com
Long Term Disability	UnitedHealthcare	306922	888.299.2070	www.myuhc.com
Short Term Disability	UnitedHealthcare	306922	888.299.2070	www.myuhc.com
Life Insurance & AD&D	UnitedHealthcare	306922	888.299.2070	www.myuhc.com
Life Planning and Legal Services	UnitedHealthcare / Optum	306922	877.660.3806	www.liveandworkwell.com
Travel Assistance Program	UnitedHealthcare	358231	800.527.0218	www.uhcglobal.com



For more information about the benefit offerings, scan the QR code below to view the Benefit Resource Center page:



Eligibility

City of Pasadena is proud to provide our employees and their families with a comprehensive and affordable benefits package, allowing you to enroll in those plans that best fit your family's needs. This guide can help you make sure you're enrolled in the benefits that best fit your life situation. At this time, you may enroll or make changes to your elections. Get ready by taking the time to know more about your options and then take action to enroll.

- **Employee Eligibility:** All FT (full-time) employees are eligible for Medical, Dental/Vision, Life and Disability benefits on the first of the month following date of hire. **For example**, if an employee begins work on May 15, 2025, his or her benefits would be effective June 1, 2025.
- **Dependent Eligibility:** Dependents eligible for coverage include your legal spouse and children under age 26. For medical, children under age 26 are eligible regardless of marital or dependent status. For dental, unmarried children under the age of 26 only. Older children who were disabled prior to the limiting age and grandchildren are also considered eligible dependents if you are their legal guardian and are claiming them as a dependent for tax purposes.
- **Benefit Enrollment Period:** After your initial enrollment period (when you first become eligible for benefits), you may enroll, waive coverage, or change your benefit elections during the stated annual open enrollment period each year (for coverage to become effective January 1) or at any time during the plan year in the event of a qualified change in status (also called a "life event"). **If you have a change in status and wish to change any of your benefit elections, you must complete an election change form within 30 days of the date of the event.**
- **Upon Your Initial Date of Eligibility:** you will be enrolled in all lines of coverage, which are 100% employer-paid (no cost to you). These lines of coverage include Group Term Life, Short-Term Disability, Long-Term Disability, and the Employee Assistance Program.

Qualified Changes in Status:

- Employee's marriage or divorce or the death of employee's spouse
- Birth, adoption, or death of a dependent child
- Change in an employee's, spouse's, or dependent child's employment status that affects benefit eligibility
- Child becoming ineligible for coverage due to reaching age 26
- Change in the employee's, spouse's, or a dependent child's residence that affects eligibility for coverage
- Employee's receipt of a Qualified Medical Child Support Order or letter from the Attorney General ordering the employee to provide (or allowing the employee to drop) Medical coverage for a child
- Changes made by a spouse or dependent child during his/her annual enrollment period with another employer
- The employee, spouse or dependent child becoming eligible or ineligible for CHIP, Medicare, or Medicaid
- Significant employer – or carrier–initiated changes in or cancellation of the employee's, spouse's, or dependent child's coverage

Supporting Documents Required to Add Dependents

Legal Spouse / Domestic Partner:

- Social Security Card (copy)
- Marriage Certificate (copy front and back)
- Declaration of Informal Marriage (Common Law)
- Your most recent joint tax return or two joint financial statements

Dependent Child(ren) Biological, Adopted, or Legal Guardian:

- Social Security Card (copy)
- Birth Certificate (copy)

Stepchildren:

- Social Security Card (copy)
- Birth Certificate (copy)
- Marriage Certificate (copy front and back)

Adopted / Court-Ordered Dependents:

- Social Security Card (copy)
- Adoption / Guardianship Documents (copy)
- Custody / Court Order Documents (copy)

FAILURE TO TURN IN THESE DOCUMENTS MAY RESULT IN DEPENDENTS NOT HAVING COVERAGE.



Medical – Broad Choice Network

Administered through UnitedHealthcare

Comprehensive, preventive healthcare helps protect you and your family from unexpected medical costs. Regular exams and screenings are affordable ways to catch issues early, preventing small problems from becoming costly. A little prevention goes a long way in maintaining your health and saving money.

	Broad Choice Network	
	Plan B	Plan C
	In-Network Only	In-Network Only
Annual Deductible (ded)	\$1,500 Ind./\$3,000 Fam.	\$3,000 Ind./\$6,000 Fam.
Maximum Out-of-Pocket	\$5,750 Ind./\$12,500 Fam.	\$5,750 Ind./\$12,500 Fam.
Routine Preventive Care	\$0 Copay	\$0 Copay
Office Visit - Tier 1 PCP	\$35 Copay	\$35 Copay
Office Visit - Standard Provider	\$35 Copay	\$35 Copay
Office Visit - Tier 1 Specialist	\$35 Copay	\$35 Copay
Office Visit - Standard Specialist	\$50 Copay	\$50 Copay
Virtual Visit	\$0 Copay	\$0 Copay
Lab and X-ray	20% after deductible	20% after deductible
Inpatient Hospital	20% after deductible	20% after deductible
Outpatient Hospital	20% after deductible	20% after deductible
Emergency Services	20% after deductible	\$200 Copay + 20% after deductible
Urgent Care Services	\$75 Copay	\$75 Copay
Inpatient Mental Health	20% after deductible	20% after deductible
Outpatient Mental Health	\$35 Copay	\$35 Copay
Rx BENEFIT		
Pharmacy Deductible	\$100 Per person	
Tier 1	\$5 or 20% Retail / \$25 Mail Order	
Tier 2	\$35 or 20% Retail / \$65 Mail Order	
Tier 3	\$35 or 20% Retail / \$65 Mail Order	

The Summary of Benefit Coverage has additional information regarding your plan. You can view it here:

[Broad Choice Plan B](#) or [Broad Choice Plan C](#)

Medical Contributions

Employees who complete the Biometric Screening, are eligible for a lower cost premium. To qualify for the Employee+Spouse and Employee+Family coverage, you and your spouse/domestic partner must complete the screening. Biometric Screening information is found on the Benefits Resource Center website, under the Wellness Programs tab.

Newly hired employees are eligible for the wellness rates. However, to continue the discounted rate employees, newly hired employees and spouses/domestic partners covered on the City's group health insurance must complete the Biometric Screening or submit a Biometric Screening Form by **December 28, 2026**.

Medical Contributions will be divided between 2 paychecks each month.

	Broad Choice Plan B		Broad Choice Plan C	
	Wellness	Non-Wellness	Wellness	Non-Wellness
Employee Only	\$80	\$130	\$30	\$80
Employee + Spouse	\$235	\$335	\$105	\$205
Employee + Children	\$174	\$224	\$78	\$128
Employee + Family	\$328	\$428	\$147	\$247

UnitedHealthcare

Medical – Nexus Network

Administered through UnitedHealthcare

Comprehensive, preventive healthcare helps protect you and your family from unexpected medical costs. Regular exams and screenings are affordable ways to catch issues early, preventing small problems from becoming costly. A little prevention goes a long way in maintaining your health and saving money.

	Nexus Network	
	Plan B	Plan C
	In-Network Only	In-Network Only
Annual Deductible (ded)	\$1,500 Ind./\$3,000 Fam.	\$3,000 Ind./\$6,000 Fam.
Maximum Out-of-Pocket	\$5,000 Ind./\$9,000 Fam.	\$6,000 Ind./\$12,500 Fam.
Routine Preventive Care	\$0 Copay	\$0 Copay
Office Visit - Tier 1 PCP	\$35 Copay	\$35 Copay
Office Visit - Standard Provider	\$70 Copay	\$70 Copay
Office Visit - Tier 1 Specialist	\$50 Copay	\$50 Copay
Office Visit - Standard Specialist	\$100 Copay	\$100 Copay
Virtual Visit	\$0 Copay	\$0 Copay
Lab and X-ray	20% after deductible	20% after deductible
Inpatient Hospital	20% after deductible	20% after deductible
Outpatient Hospital	20% after deductible	20% after deductible
Emergency Services	20% after deductible	\$200 Copay + 20% after deductible
Urgent Care Services	\$75 Copay	\$75 Copay
Inpatient Mental Health	20% after deductible	20% after deductible
Outpatient Mental Health	\$50 Copay	\$50 Copay
Rx BENEFIT		
Pharmacy Deductible	\$100 Per person	
Tier 1	\$5 or 20% Retail / \$25 Mail Order	
Tier 2	\$35 or 20% Retail / \$65 Mail Order	
Tier 3	\$35 or 20% Retail / \$65 Mail Order	

The Summary of Benefit Coverage has additional information regarding your plan. You can view it here:

[Nexus Plan B](#) or [Nexus Plan C](#)

Medical Contributions

Employees who complete the Biometric Screening, are eligible for a lower cost premium. To qualify for the Employee+Spouse and Employee+Family coverage, you and your spouse/domestic partner must complete the screening. Biometric Screening information is found on the Benefits Resource Center website, under the Wellness Programs tab.

Newly hired employees are eligible for the wellness rates. However, to continue the discounted rate employees, newly hired employees and spouses/domestic partners covered on the City's group health insurance must complete the Biometric Screening or submit a Biometric Screening Form by **December 28, 2026**.

Medical Contributions will be divided between 2 paychecks each month.

	Nexus Choice Plan B		Nexus Choice Plan C	
	Wellness	Non-Wellness	Wellness	Non-Wellness
Employee Only	\$55	\$105	\$15	\$65
Employee + Spouse	\$192.50	\$292.50	\$53	\$153
Employee + Children	\$143	\$193	\$39	\$89
Employee + Family	\$270	\$370	\$74	\$174

Medical – Charter Network

Administered through UnitedHealthcare

Comprehensive, preventive healthcare helps protect you and your family from unexpected medical costs. Regular exams and screenings are affordable ways to catch issues early, preventing small problems from becoming costly. A little prevention goes a long way in maintaining your health and saving money.

	Charter Network	
	Plan B	Plan C
	In-Network Only	In-Network Only
Annual Deductible (ded)	\$1,500 Ind./\$3,000 Fam.	\$3,000 Ind./\$6,000 Fam.
Maximum Out-of-Pocket	\$5,000 Ind./\$9,000 Fam.	\$6,000 Ind./\$12,500 Fam.
Routine Preventive Care	\$0 Copay	\$0 Copay
Office Visit - Standard Provider	\$35 Copay	\$35 Copay
Office Visit - Standard Specialist	\$50 Copay	\$50 Copay
Virtual Visit	\$0 Copay	\$0 Copay
Lab and X-ray	20% after deductible	20% after deductible
Inpatient Hospital	20% after deductible	20% after deductible
Outpatient Hospital	20% after deductible	20% after deductible
Emergency Services	20% after deductible	\$200 Copay + 20% after deductible
Urgent Care Services	\$75 Copay	\$75 Copay
Inpatient Mental Health	20% after deductible	20% after deductible
Outpatient Mental Health	\$35 Copay	\$35 Copay
Rx BENEFIT		
Pharmacy Deductible	\$100 Per person	
Tier 1	\$5 or 20% Retail / \$25 Mail Order	
Tier 2	\$35 or 20% Retail / \$65 Mail Order	
Tier 3	\$35 or 20% Retail / \$65 Mail Order	

The Summary of Benefit Coverage has additional information regarding your plan. You can view it here: [Charter Plan B](#) or [Charter Plan C](#)

Medical Contributions

Employees who complete the Biometric Screening are eligible for a lower cost premium. To qualify for the Employee+Spouse and Employee+Family coverage, you and your spouse/domestic partner must complete the screening. Biometric Screening information is found on the Benefits Resource Center website, under the Wellness Programs tab.

Newly hired employees are eligible for the wellness rates. However, to continue the discounted rate employees, newly hired employees and spouses/domestic partners covered on the City's group health insurance must complete the Biometric Screening or submit a Biometric Screening Form by **December 28, 2026**.

Medical Contributions will be divided between 2 paychecks each month.

	Charter Choice Plan B		Charter Choice Plan C	
	Wellness	Non-Wellness	Wellness	Non-Wellness
Employee Only	\$55	\$105	\$15	\$65
Employee + Spouse	\$193	\$293	\$53	\$153
Employee + Children	\$143	\$193	\$39	\$89
Employee + Family	\$270	\$370	\$74	\$174



Which Network Is Best for Me?

The City of Pasadena offers two medical plan designs for employees and eligible dependents. In addition, there are three network options to select. The below chart compares basic information regarding the network differences. To view a more in-depth analysis, please visit: [Network Grid](#)

	Choice Plan B & C	Nexus Plan B & C	Charter Plan B & C
What providers can I use?	Any Provider in the Broad UHC Network	Memorial Hermann & UT Physicians	Kelsey Seybold Physicians & Clinics
Are there benefits available outside of the network I select?	No - you must use providers in-network. If you go outside of the network (other than a true Emergency), you will be 100% responsible for the cost of your care. You can change providers to access your benefits through UHC.		
Whose responsibility is it to know if my provider is in network?	It is the member's responsibility to confirm that the provider, from whom you are seeking treatment is in the network you have selected.		
Do I need to select a Primary Care Provider (PCP)?	No		
Do I need a referral to see a Specialist in my chosen network?	No		
Are all major hospital systems included in my network?	Yes	Yes - Use Memorial Hermann facility for lower cost-sharing.	Yes - However, you will need a referral from a Kelsey provider to access care at MD Anderson.
What is a Tier 1 provider?	Tier 1 Providers have been evaluated for quality of care, health outcomes, and overall cost. They are designated by UHC, and the member may have a lower copay for seeking care from a Tier 1 Provider.		The Charter Network does not have this designation available.
What if I have a dependent living outside of the service area?	Your dependent will have access to the UHC broad network to seek care.		Your dependent has access to Virtual Visits at a \$0 copay and Urgent Care services. All other care will require a referral from a Kelsey provider.

To see if your current provider participates in these networks, you can visit:

- Choice Broad Network: www.welcometouhc.com/choice
- Nexus Network: www.welcometouhc.com/nexus2
- Charter Network: www.welcometouhc.com/charter

UnitedHealthcare Resources

UnitedHealthcare® app

Digital tools to keep you connected

Your personalized digital tools — the **UnitedHealthcare® app** and **myuhc.com®** — give you access to resources designed to help you:

- View benefit info, claim details and account balances
- Search network providers and facilities for the type of care you may need
- Access your health plan ID card and add your plan details to your smartphone's digital wallet
- Learn about covered preventive care
- Compare cost estimates before you get care, which may help you save money



Register once to access both tools

Start by opening the **UnitedHealthcare app** or going to **myuhc.com** and then:

- Tap **Register Now** on the app, or select **Register** on the website
- Fill in the required fields and create your username and password
- Enter your contact information and select SMS text or phone call for two-factor authentication — then, agree to the terms and conditions
- Opt in to paperless delivery from your communication preferences

Now that you're registered, you'll be able to manage your plan all year long.

Emotional Wellbeing Solutions

Support for Everyday Life – Available 24/7 at no cost to you

This includes referrals, seeing network providers, initial consultations with mediators or financial and legal experts, and access to our digital experience, which will guide you through available benefits.

Help is available over the phone or online, anytime

Emotional Wellbeing Navigation Specialists are available by phone to provide help with a range of life concerns and stressors, including:

- Relationship problems
- Workplace conflicts and changes
- Parenting and family issues
- Caregiver support
- Stress, anxiety and depression
- Legal and financial concerns



800-331-3566

Or sign in to
liveandworkwell.com

**Enter your company access code:
Pasadena**

You can also access **6 coaching and counseling sessions** either in person or virtually with a provider in our large network — at no cost. All conversations are confidential, and we never share your personal records with your employer or anyone else without your permission.

United
Healthcare

Know Where to go for Care

When you need care, call your primary care physician or family doctor first.

Your physician has easy access to your records, knows the bigger picture of your health, and may even offer same-day appointments to meet your needs. When seeing your physician is not possible, however, it's important to know your quick care options to find the place that's right for you and help avoid financial surprises.

	Quick Care Options	Needs or Symptoms	Costs	
	24/7 NurseLine Call the number on your health plan ID card for expert advice.	<ul style="list-style-type: none"> Choosing where to get medical care Finding a provider or hospital 	<ul style="list-style-type: none"> Health and wellness help Answers to questions about medicines 	No additional cost
	Virtual Visits Anywhere, anytime online doctor visits.	<ul style="list-style-type: none"> Bladder infection Bronchitis Cold/flu 	<ul style="list-style-type: none"> Fever Pink eye Sinus problems 	\$
	Convenience Care Clinic Treatment that's nearby.	<ul style="list-style-type: none"> Skin rash Flu shot 	<ul style="list-style-type: none"> Minor injuries Earache 	\$\$
	Urgent Care Center Quicker after-hours care.	<ul style="list-style-type: none"> Low back pain Respiratory (cough, pneumonia, asthma) Stomach (pain, vomiting, diarrhea) 	<ul style="list-style-type: none"> Infections (skin, eye, ear/nose/throat, genital-urinary) Minor injuries (burns, stitches, sprains, small fractures) 	\$\$\$
	Emergency Room (ER) For serious, immediate needs.	<ul style="list-style-type: none"> Chest pain Shortness of breath Severe asthma attack 	<ul style="list-style-type: none"> Major burns Severe injuries Kidney stones 	\$\$\$\$

See a doctor whenever, wherever. Get care in 20 minutes or less.

When you're sick and need care quick, a Virtual Visit is a convenient way to start feeling better faster. With a Virtual Visit, you can see and talk to a doctor via mobile device or computer —24/7, no appointment needed. The doctor can give you a diagnosis and prescription, if needed.

To get started with a Virtual Visit, go to uhc.com/virtualvisits.

Prepare for your Virtual Visit

Have these 3 items ready to register and complete your Virtual Visit:

- Health plan ID card
- Credit card
- Pharmacy location

Naviguard Member Journey

How Naviguard works for members.

We're experts at resolving unexpected out-of-network balance medical bills by negotiating directly with providers. Our services are available at **no additional cost to you** through your UnitedHealthcare-administered health plan benefits.

We are with the member every step of the way.



1. Call UnitedHealthcare Member Services

Following an Explanation of Benefits (EOB) statement, if a member gets balance billed, they will call UnitedHealthcare Member Services to get started with Naviguard.



2. Connect to an Advisor

Member is connected with a dedicated Naviguard Advisor, through our secure portal or telephone, to share their story, upload their out-of-network bill, and sign two forms so we can begin negotiating on their behalf.



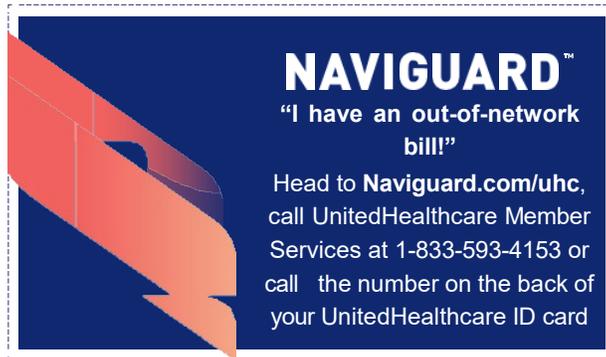
3. Negotiation Begins

Naviguard begins negotiations with the out-of-network provider while keeping the member up-to-date on progress.



4. Outcome is Reached

The dedicated Naviguard Advisor connects with the member to share the final outcome of negotiations. A new Explanation of Benefits (EOB) may also be sent.



NAVIGUARD™
"I have an out-of-network bill!"
Head to [Naviguard.com/uhc](https://naviguard.com/uhc), call UnitedHealthcare Member Services at 1-833-593-4153 or call the number on the back of your UnitedHealthcare ID card

Maven Maternity Program

Maven Maternity Care

Maven is here to give you free 24/7 support for your pregnancy and postpartum journey. Maven is the world's largest virtual clinic for women and families, and you have free access as a UnitedHealthcare member.

You can use Maven for:

- 24/7 virtual appointments and messaging with providers like OB-GYNs, doulas, lactation consultants, mental health specialists, and pediatricians.
- A dedicated Care Advocate to help you make sense of your benefits and find the right Maven providers for you.
- Access to hundreds of expert-approved articles, drop-in groups, and on-demand classes like Childbirth 101 and Infant CPR.

Have questions? We have answers.

Here are some Maven FAQs:

What can I use Maven for?

Everything from getting your questions answered in between in-person visits, to creating your birth and postpartum plans, to managing your mental health, breastfeeding or bottle feeding, infant sleep, and so much more.

Is it really free?

Yes! As a UnitedHealthcare member, everything on Maven is free for you, including all virtual appointments, Care Advocate messaging, articles, classes, and drop-in groups.

How often can I meet with providers?

As much as you want. Seriously, even at 2am. And Maven visits are always free—no copays or in-app costs.

How does Maven support high risk pregnancies?

Once you meet with your Care Advocate, Maven will curate a Care Team of specialists that address your specific needs like high-risk OB-GYNs, diabetes educators, nutritionists, etc. Your Care Advocate will also be checking in on you throughout your pregnancy.

The screenshot shows the Maven app interface. At the top is the Maven logo. Below it is the heading "Meet your dedicated Care Team". A message reads: "We're here to support you for anything you need. On Maven, you'll get healthcare the way it should be." Below this is a circular profile picture of a woman named Skye, identified as "Your Maven Care Advocate" and "Your personal healthcare concierge". Underneath are three more team members, each with a circular profile picture and name/role: Judi Li (Lactation Consultant), Jamie Hutton (Mental Health Provider), and Meredith Kinney (Pediatric Sleep Coach).

[Activate your account | Maven Clinic](#)



You can use Maven to get expert support, day or night, with:

- Creating your birth plan
- Managing your emotional wellbeing and mental health
- Keeping you healthy during pregnancy

Get the help you need for your pregnancy—for free. (Yes, seriously).



City of Pasadena Health & Wellness Center

Primary care for employees and dependents covered on the health plan.

Treatments and services include:

- Allergies / Asthma
- Annual Physicals
- Cold / Flu / Congestion
- Diabetes Management
- High Blood Pressure
- High Cholesterol
- Lab Work / Tests
- Minor Injuries
- Personal Health Assessments
- Sick Visits
- Sports Physicals
- Thyroid Disorders
- Tobacco Cessation
- Well Woman Exams



Joette Gracia, MD is board certified in Family Medicine.

Pay nothing, get everything.

- \$0 Copay
- \$0 Deductible
- \$0 Coinsurance
- \$0 On-site labs
- Fast, easy appointment access
- Preventive, illness, minor injury care, and chronic disease management
- Less wait time, more face time with your medical provider

**Show Me
The App!**



City of Pasadena Health & Wellness Center
2910 Southmore Ave, Pasadena
M / W / F 8am - 2:30pm
Tu / Th 9am - 1pm / 1:30pm - 5pm

Activate your patient account

Visit www.careatc.com/activate or download the CareATC app and follow the registration prompts.

Three easy ways to schedule an appointment:



713.920.7958

www.careatc.com/patients



CareATC app



Dental

Insured by Humana

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the City of Pasadena's dental benefit plans.

BENEFIT	PPO	DHMO
Calendar Year Deductible	\$50 per person \$150 per family	None
Preventive Care (Cleanings, Exams, X-ray)	100% Covered	Various copays
Basic Care (Endo, Perio, Oral Surgery)	10% after deductible	Various copays
Major Care (Crowns, Bridges, Dentures)	40% after deductible	Various copays
Orthodontics (Adults & Children)	50% after deductible, Lifetime Max \$1,500	Various copays
Annual Benefit Maximum	\$1,500 per person	Unlimited

PPO Extended Annual Maximum

Humana's extended annual maximum gives you continued access to your dental benefits after you reach the annual maximum of your plan.

How it Works

- Humana will pay 30% of covered charges – even after you've used the annual max dollar amount of your plan.
- Extended coverage allows you to continue to pay less with in-network discounts on covered services when you see an in-network dentist.

Dental Contributions

Dental contributions will be deducted from your paycheck once a month.

	Humana DPPO	Humana DHMO
Employee Only	\$9.32	\$0.23
Employee + Spouse	\$40.75	\$8.03
Employee + Children	\$40.43	\$8.90
Employee + Family	\$66.92	\$18.43



Humana

Dental

How to Find a Dentist in the Network:

Visiting a dentist in the Humana network ensures you're getting the lowest cost for dental care. To find an in-network dentist for each plan, follow these steps:

PPO:

Step 1: Scan the QR code or go to humana.com/findadentist and select the "Dentist" tab.



Step 2: Enter your search information based on plan

- Enter your **ZIP code**
- In the popup window, choose "**PPO**" for "Coverage Type"
- Select the network: PPO/Traditional Preferred plans
- Click the "**Select**" button
- On the next screen, click on the "**all dental providers**" link located below the "Dentist name or specialty" entry box to get a list of all providers.

DHMO:

Step 1: Scan the QR code or go to humana.com/findadentist and select the "Dentist" tab.



Step 2: Enter your search information based on plan

- Enter your **ZIP code**
- In the popup window, choose "**DHMO**" for "Coverage Type"
- Select the network: **HS405 DHMO**
- Click the "**Select**" button
- On the next screen, click on the "**all dental providers**" link located below the "Dentist name or specialty" entry box to get a list of all providers.
- Choose a dentist from the search results, call to confirm their accepting new patients, and then take note of their **Dental ID** number.
- After you enroll, the dentist you selected will need to be assigned as your Primary Care Dentist (PCD) **BEFORE** you get dental services.

You must contact Humana using the number on the back of your ID card and provide the Dental ID number for your chosen PCD.

MyHumana on the Go

Once you become a Humana plan member, you get the most out of your plan with a MyHumana account, and take your Humana essentials wherever you go with the MyHumana mobile app.

Once your Humana plan coverage begins, go to MyHumana.com to activate your account or download and register on the MyHumana app for iOS and Android.

Is your dentist missing from the Humana network?

We don't want you to have to choose between continuing to see your dentist and receiving the best possible value from your dental benefit plan.

You can help us get your dentist in our network. **Scan the QR code and fill out the online form to refer your dentist.**



Vision

Insured by Community Eye Care (CEC)

Routine eye exams can lead to early detection of vision problems and other diseases such as diabetes, hypertension, multiple sclerosis, high blood pressure, osteoporosis, and rheumatoid arthritis.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK REIMBURSEMENT
Exams and Materials	\$0 at Visionworks or \$10 Copay	Members are reimbursed 100% for services incurred minus applicable copay
Frame	\$200 Flexible Allowance Applies to Frames & Lenses	
Standard Lenses		
Contact Lenses	\$200 Flexible Allowance Applies to Contact Lenses Fitting & Evaluation: \$0 at Visionworks or \$40 Copay	
Frequency	Exam: 1 Every Calendar Year Contacts / Frames / Lenses: Every 12 months	
Laser Vision Correction	35% Discount with Participating Providers	N/A

Your flexible eyewear allowance may be used for *glasses, contacts, and non-prescription eyewear that includes sunglasses, safety glasses, readers, and blue-light filtering glasses.*
Please review the following page to learn how to get the most out of your vision benefits!

How to Use Your Vision Benefits

Follow these simple steps to access and use your CEC vision benefits:

- Register and log in to the Member Portal at cecvision.com/members/login. You will need your Member ID number in order to register. If your ID number is not readily available and you need assistance, please contact us at **888-254-4290**.
- Review your vision benefit information.
- Find an in-network provider near you and schedule your appointment.

Vision Contributions

Vision contributions will be deducted from your paycheck once a month.

	Vision
Employee Only	\$7.06
Employee + Spouse	\$14.11
Employee + Children	\$14.54
Employee + Family	\$20.12



Get the Most Out of Your Vision Plan

Your vision benefits with CEC are available every year, at any time, with no surprise costs. All plans include:



Eye Exam
An annual routine eye exam with an optometrist or ophthalmologist



Eyewear Allowance
An annual flexible allowance to use for prescription and non-prescription eyewear.



Contact Lens Fitting
An annual contact lens fitting, re-fit, or evaluation.



Skip the Copays

When visiting a Visionworks location, you can save with \$0 copays on exams, eyewear purchases, and contact lens fittings!



[Find a Location](#)

WARBY PARKER

You have a \$200 flexible allowance and choose to visit Warby Parker®. Let's see how you can use it...



Basic frames	\$95
Polycarbonate lenses (single vision)	Included
UV coating	Included
Scratch-resistant coating	Included
Anti-reflective coating	Included
Total Cost	\$95
CEC Annual Flexible Allowance	\$200
Rx Glasses from Warby Parker®	\$95
Remaining Balance	\$105

Apply any remaining allowance to lower the cost of contacts OR use it towards sunglasses for yourself or family!

Popular Retail Optical Chains



Flexible Spending Accounts

Administered through WEX

PLAN	HEALTH CARE FSA	DEPENDENT CARE FSA
Tax-free earnings pay for:	Medical, dental and vision expenses for you and your dependents	Day care expenses for your eligible dependents
Important Information:	<p>Eligible expenses include:</p> <ul style="list-style-type: none"> ▪ Deductibles, copays, coinsurance ▪ Prescription drugs, allergy shots, insulin, syringes, physicals ▪ Chiropractor treatments, psychiatric and psychologist fees ▪ Smoking cessation programs, weight loss programs for disease ▪ Wheelchair/crutches or other durable medical equipment ▪ Non-cosmetic dental care, including exams, x-rays, fillings, and root canals ▪ Eye exams, prescription eyeglasses, and prescription sunglasses ▪ Corrective eye surgery (LASIK, cataract, corneal rings, etc) ▪ Contact lenses, cleaning solutions ▪ Hearing exams, aids & batteries ▪ And more 	<p>Eligible dependent care expenses for:</p> <ul style="list-style-type: none"> ▪ Dependent children under age 13 ▪ A disabled spouse who is mentally or physically incapable of self care ▪ Your dependent who is physically or mentally not able to care for himself or herself and for whom you can claim an exemption (or could claim an exemption except the person had \$3,000 or more of gross income) ▪ NOTE: Expenses must be incurred during the period of coverage. Please see IRS Publications 502 and 503 details of Medical and Dependent Care Reimbursement rules
Annual Contribution Maximums	\$3,400 maximum	\$2,500 max if tax-filing single \$5,000 max if married and filing jointly or a single parent
“Use it or Lose it”	Any amount not spent will be forfeited after March 15th of the following year.	Any amount not spent will be forfeited at year end (December 31).
Tax Information	Contributions are made on a pre-tax basis; expenses claimed under your health care or dependent care FSA may not be claimed as a tax credit on your federal tax return.	



Disability

Insured by and Administered through UnitedHealthcare

City of Pasadena provides employer-paid Disability benefits, which all full-time employees working 40 hours a week receive at no cost. For additional details, ask HR for a copy of the plan documents.

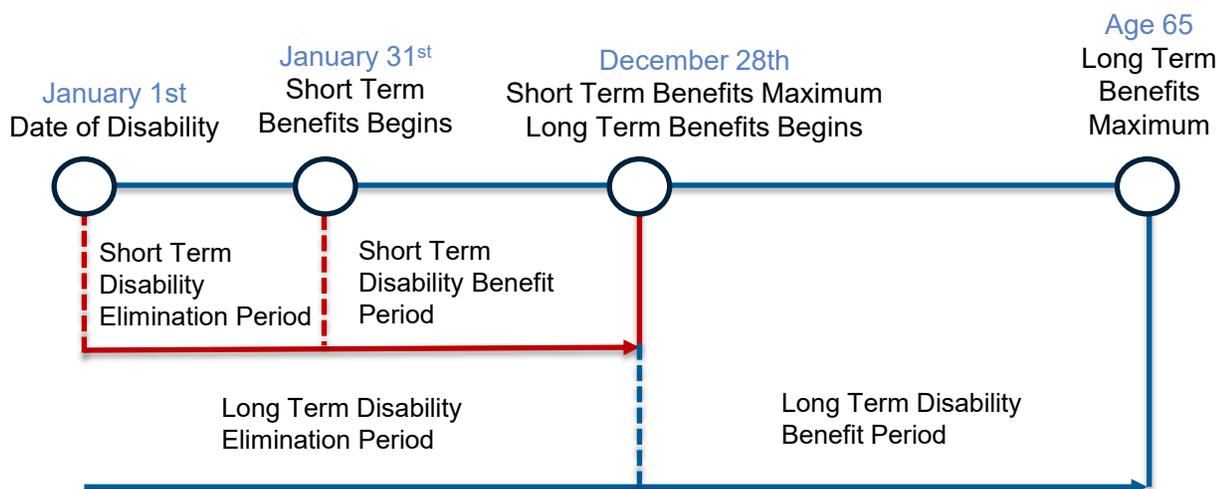
Short Term Disability

- Weekly benefit of up to 60% of weekly earnings
- Coverage begins on 31st day off the job
- Coverage lasts up to 48 weeks
- Maternity Coverage is Included

Long Term Disability

- Monthly benefit of up to 60% of monthly earnings
- \$6,000 maximum monthly benefit
- Coverage begins on 361st day off the job
- Coverage lasts until age 65 (see COC for more info)
- First 24 Months look at Own Occupation

How Short Term Disability & Long Term Disability Work Together



Note: Benefits will end when you are no longer considered to meet the definition of disabled; otherwise, will run to the maximum allowable by the plan

Group Term Life / AD&D

Insured by UnitedHealthcare

Life insurance can provide security for your dependents in the event of your death or terminal illness. The City of Pasadena provides a basic level of life insurance for all full-time employees of \$25,000.

Optional Term Life and AD&D

Employees can purchase additional Life Insurance and AD&D. To enroll, complete and submit the enrollment form to the Insurance Coordinator. You can access the form here: [2026 Life and AD&D Election Form](#)

Employee Coverage

- 5x your annual salary, up to \$500,000 whichever is less
- Increments of \$10,000
- Guaranteed issue limit: \$200,000

Dependent Coverage

- Dependent coverage no more than EE Coverage
- Spouse coverage in units of \$5,000, up to \$25,000
- Spouse Guaranteed issue limit: \$25,000
- Child coverage in units of \$2,000 up to \$10,000
- Child Guaranteed issue limit: \$10,000 after 6 months of age, Live Birth to 6 months: \$1,000

Existing amounts will be grandfathered without Evidence of Insurability (EOI). If you are applying for new supplemental coverage more than 31 days after you first became eligible or requesting an amount over the Guaranteed Issue amount, you must submit an Evidence of Insurability (EOI) form. You can access the form here: [Evidence of Insurability Form](#)

Benefit coverage reduces for employee and spouse beginning at employees' attainment of age 65.

Employee: The rates shown below are per \$10,000 of coverage for employee.					
Your Age	Cost Per Month	Your Age	Cost Per Month	Your Age	Cost Per Month
Under Age 24	\$0.50	Age 40-44	\$1.45	Age 60-64	\$8.90
Age 25-29	\$0.70	Age 45-49	\$1.95	Age 65-69	\$15.20
Age 30-34	\$0.70	Age 50-54	\$3.56	Age 70-74	\$29.50
Age 35-39	\$1.05	Age 55-59	\$5.98	Age 75+	\$59.60
Spouse: The rates shown below are per \$5,000 of coverage for spouse and are based on employee age.					
Your Age	Cost Per Month	Your Age	Cost Per Month	Your Age	Cost Per Month
Under Age 24	\$0.25	Age 40-44	\$0.73	Age 60-64	\$4.45
Age 25-29	\$0.35	Age 45-49	\$0.98	Age 65-69	\$7.60
Age 30-34	\$0.35	Age 50-54	\$1.78	Age 70-74	\$14.75
Age 35-39	\$0.53	Age 55-59	\$2.99	Age 75+	\$29.80
Child: Child rate is \$0.50 for \$2,000 of coverage.					

Employee Wellbeing Solution

When you have a long list of stressors — and a longer list of to-dos

When you're dealing with the pressures of everyday life, it can be easy to simply smile and say, "I'm fine." But sometimes, emotions like stress, sadness or even anger can linger.

In those moments, Employee Wellbeing Solution is here for you. It's a modern, flexible employee assistance program (EAP) that offers support for everyday life. Call anytime to speak with an Employee Wellbeing Navigation Specialist who'll listen to your needs and connect you with resources that can help. It's available to all members of your household, including children living away from home.

Employee Wellbeing Solution is available 24/7 at no cost to you

This includes referrals, seeing network providers, initial consultations with mediators or financial and legal experts, and access to our digital experience, which will guide you through available benefits.

Help is available over the phone or online, anytime

Employee Wellbeing Navigation Specialists are available by phone to provide help with a range of life concerns and stressors, including:

- Relationship problems
- Workplace conflicts and changes
- Parenting and family issues
- Caregiver support
- Stress, anxiety and depression
- Legal and financial concerns

Support for everyday life



To learn more, scan the QR code or visit www.liveandworkwell.com

To find the right support for you, enter your company access code: Pasadena

1-800-331-3566



24/7 availability

| Confidential

| No Cost to you

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

WHAT IS “BALANCE BILLING” (SOMETIMES CALLED “SURPRISE BILLING”)?

- When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.
- “Out-of-network” describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.
- “Surprise billing” is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

EMERGENCY SERVICES

- If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

CERTAIN SERVICES AT AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER

- When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.
- If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.
- You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
- Cover emergency services without requiring you to get approval for services in advance (prior authorization).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Human Resources.

Required Annual Notices

Scan QR Code or click the link

[Participant Notices](#) 



[CHIP](#) 



The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by your employer. The text contained in this Summary was taken from various summary plan descriptions and benefits information. While every effort was taken to report your benefits, discrepancies or errors are always possible. In case of a discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this Summary, contact Human Resources.

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