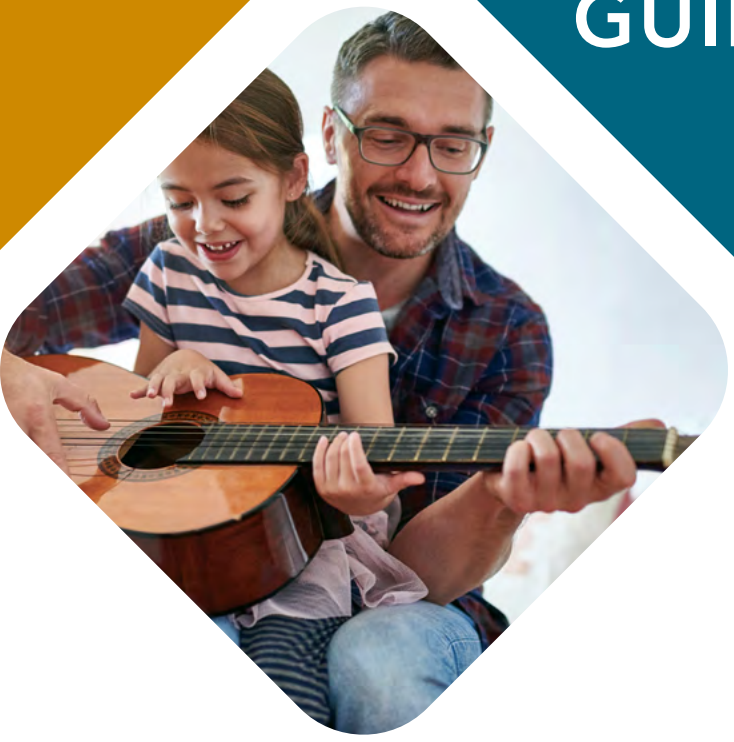
2020

EMPLOYEE BENEFITS GUIDE



CITY OF BERKELEY

Employee Benefits Guide 2020

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

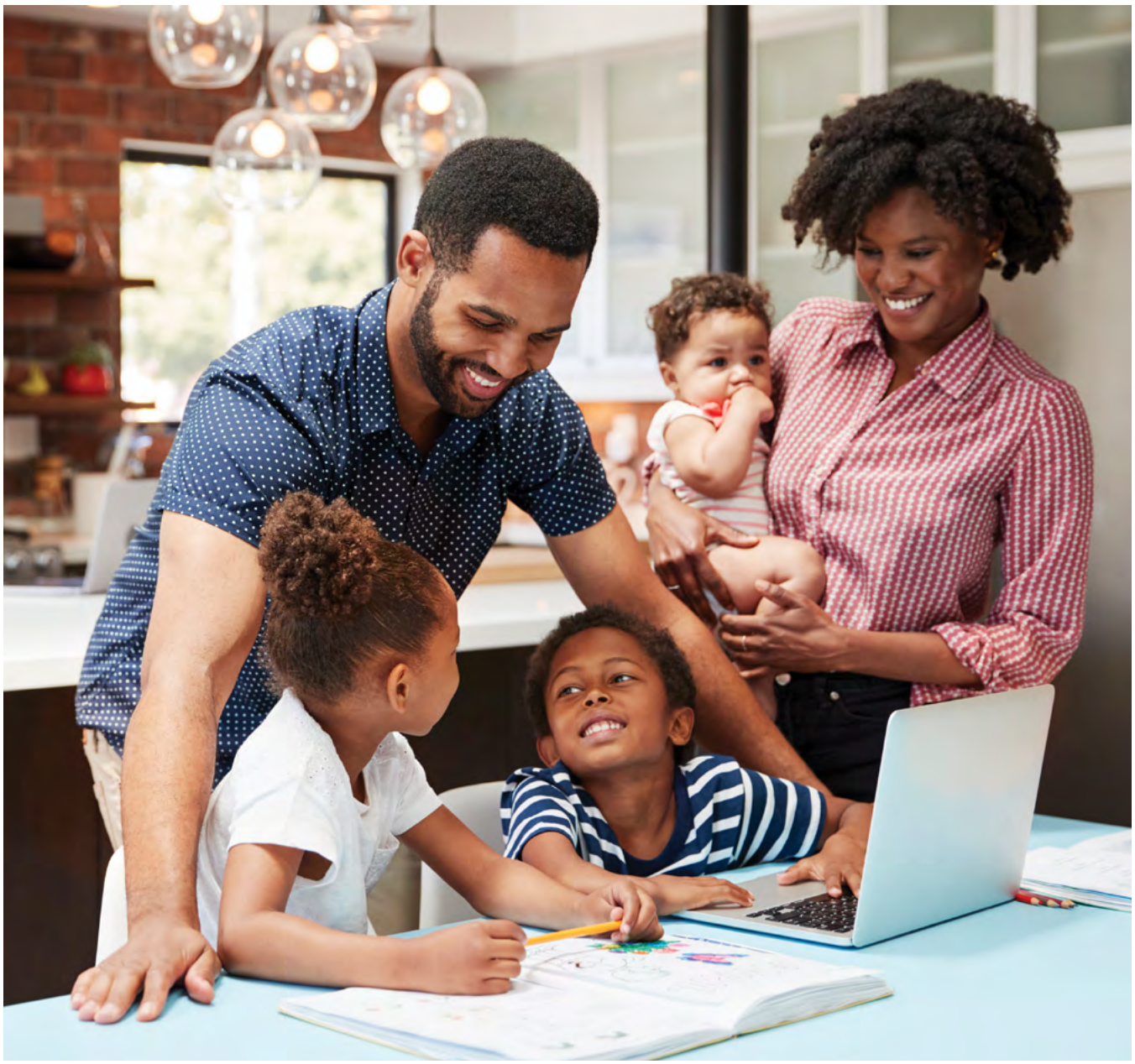
Please see page 34 for more details.

Introduction

Summary

This Benefits Guide is provided for employees to have a comprehensive resource for the City of Berkeley's (the City) health, welfare and retirement benefits. This Guide is not intended to be a contract (expressed or implied), nor is it intended to otherwise create any legally enforceable obligations on the part of the City, its agents, or its employees.

The purpose of this Guide is to summarize the City's employee benefits and the policies and procedures regarding these benefits. For the most detailed and up-to-date information, please refer to the appropriate plan document, evidence of coverage booklet, insurance policy or contract, as well as applicable rules, regulations, resolutions, ordinances and Memoranda of Understanding/Memoranda Agreement. These documents can be obtained by contacting the Human Resources Department and on the Human Resources Groupware page on iCoBWEB (the internal City of Berkeley website).



Benefit Choices

The City of Berkeley recognizes that your benefits are an important part of the reason you choose to work here. The City provides a variety of high quality benefits largely paid for by the City or at a reasonable cost to you. You can also choose between different optional benefits to meet your individual and family needs.

Since you have some choices to make, it is important to understand the various programs. That is why this Handbook is being provided for you. There are also individual brochures for each of the benefit plans available in the Human Resources department.

Benefits provided by the City for eligible employees include retirement plans, medical plans, a dental plan, group life insurance, disability coverage, an employee assistance plan, and a computer eye care program. Benefited employees may also elect to participate in these additional voluntary options:

- Deferred Compensation Plan
- YMCA membership
- Flexible Spending Account
- Cash-in-Lieu of Health Insurance
- Dependent Care Assistance Plan
- Cash-in-Lieu of Dental Insurance
- Supplemental Life Insurance
- Commuter Check

Eligibility

To be eligible for benefits, you must be scheduled to work at least 20 hours per week as a benefited Career or regular at-will employee (BMC 4.04.120, (a), (b), or (c)). Most benefits are effective the first day of the month after you are hired. This is true whether you are hired on the first or last day of the month. Your spouse or approved domestic partner and dependent children may be covered, but remember, many benefits are NOT automatic!

Note: In order to be covered by the City's benefits, you must enroll within 30 calendar days of your hire date.

If you miss this enrollment window, you must wait until the next open enrollment period and will not be covered during this time. If you are recently married, or have a newborn or adopted child, you must enroll your new dependent within 30 calendar days of the event. To enroll, complete an enrollment form and return it to the Human Resources Department.

If you take a leave of absence without pay (LWOP) for two full pay periods or more (160 consecutive hours), all of your benefits will be discontinued. There are certain exceptions to this rule in terms of your medical insurance. Under the federal Family and Medical Leave Act and the California Family Rights Act, you may be entitled to medical coverage for up to 12 weeks from the date of disability (not the LWOP date). Also, if you take parental leave (or sabbatical leave for Local 1021 – Community Services and PTRLA Chapter and Local 1 employees), your medical coverage will be continued for up to one year, provided you meet the qualification requirements.

You do have the option to continue paying for your medical insurance (as well as dental and life insurance) until you return. Contact the Payroll Audit Division (2nd floor) to find out how to pay for benefits while on LWOP. If your medical coverage is canceled due to non-payment, you must re-enroll within 30 calendar days of your return to work.

Open Enrollment

Once a year, the City holds an Open Enrollment period. During this time, you may change to a different medical plan, enroll in the dental plan, the Cash-in-Lieu option, Flexible Spending Account and Dependent Care Assistance Plan. You may also add dependents to your medical and dental coverage. Check your Berkeley Matters for more information.

Benefit Choices (continued)

Enrollment Instructions

When you are hired, you have 30 calendar days to make your choices and most of your benefits will be effective the first day of the month following the month you are hired. Read over all of the material carefully. If you have any questions or require assistance in making these important choices, you can contact the Benefits Specialist in the Human Resources Department at 510.981.6800.

Here are some basic guidelines you need to keep in mind when going over these choices:

1. Review the section of this Handbook on medical plans, the health plan comparison, as well as the enrollment packets to determine which medical plan best suits your health and financial needs.
2. If you pay for childcare expenses or day care for an elder dependent, you may be eligible to pay for those expenses out of pre-tax dollars by enrolling in the Dependent Care Assistance Plan.
3. Determine your life insurance needs and decide if you wish to buy additional coverage above that provided by the City.
4. Study the Deferred Compensation information. You may enroll in this benefit at any time by calling the Deferred Compensation Representative(s) of your choice to discuss your options.
5. If you have medical coverage through another source, such as a spouse, you may want to consider the cash-in-lieu option.

Once you have made your choices, you should complete the appropriate enrollment forms and turn them into the Human Resources Department within 30 calendar days of your hire date. Be sure to include all your eligible dependents. Remember to complete all beneficiary forms.

2020 Domestic Partner Benefits

The City was one of the first employers in the country to provide employee domestic partner benefits. Since 1985, the City has provided medical and dental coverage as well as family sick leave and bereavement leave for employees with approved domestic partners. In order to be eligible for these benefits, the employee and domestic partner must complete and sign an Affidavit of Domestic Partnership available in the Human Resources Department. The employee must also provide evidence that they have resided together at the same address for at least six months.

Note: *The City withholds taxes based on the value of this benefit unless the employee claims the domestic partner as a dependent on his or her income taxes (or in the case of State taxes, if they are registered with the State as domestic partners). For more information about domestic partner benefits for City employees, contact the Human Resources Department. If you terminate a domestic partnership, you must complete a Termination of Domestic Partnership Form and return it to the Human Resources Department.*

Tax Treatment of Health Benefits

Important Notice

On June 26, 2013, the U.S. Supreme Court ruled that the federal ban on recognizing same-sex marriages was unconstitutional. As a result, same-sex married partners are legally considered married and are to be treated the same as opposite-sex married partners in all respects under Federal law, which means they may now be eligible for benefits to which they were not previously entitled—for example, payment of health insurance premiums on a pre-tax basis, COBRA continuation rights, and other benefits for which spouses are eligible. Any legally married same-sex partner should review his or her employee benefits elections to ensure that he or she is maximizing what is available to same-sex marriage partners. The law has not changed with respect to same-sex domestic partners who are not married.

Benefit Choices (continued)

Change in Beneficiaries

Certain events in your life such as marriage, divorce, or a death in the family can affect who you name as your designated beneficiary for certain benefits. You may change your beneficiary(ies) at any time. You can obtain most beneficiary forms in the Human Resources Department. You can designate a beneficiary for the following plans:

- **Retirement –** CalPERS
- **Life Insurance –** Hartford
- **Deferred Compensation –** Mass Mutual
- **Deferred Compensation –** Prudential
- **Deferred Compensation –** CalPERS
- **SRIP –** Mass Mutual
- **SRIP –** Prudential
- **PARS**

Mail the completed CalPERS beneficiary form directly to the address on the form. Return the SRIP Deferred Compensation, and Life Insurance forms to the Human Resources Department.

Part-Time Employees

Benefited career employees who work at least 20 hours per week, but less than 40, receive dental benefits on a prorated basis. Medical benefits are calculated differently. Unrepresented employees receive medical benefits based on the percentage of their work schedule. Unionized employees who work 50-74% time receive 75% City-paid medical, and those who work 75% time or more receive 100% City-paid medical (up to the Kaiser family rate).

The City's contributions to CalPERS, SRIP, and Long Term Disability (LTD) are based on earnings. The City pays other benefits, such as the group life insurance, in full.

Note: *Medical insurance deductions are made on a pre-tax basis and dental insurance deductions are made on a post-tax basis. Employees who pay part of their premium may only enroll or cancel their coverage when there is a change in family status or during the annual Open Enrollment per IRS regulations.*

Benefit Resources

For employee benefits questions, contact the Human Resources Department. For payroll deductions or enrollment questions in CalPERS, SDI, health and dental contact the Payroll Audit Division (2nd floor).

- **BenefitBridge:** The Web site for your benefits needs. Through a single portal accessed via the Internet, BenefitBridge allows you to enroll in benefit plans as well as access specific information about the plans available to you, about your enrollment, health care and other benefit-related information. Employees may also use BenefitBridge to compare plans and rates. You may also research information about life events such as marriage, birth of a child and retirement and see how your benefits can be affected by these life events and gain a better understanding of the alternatives available to you.
- **Berkeley Matters:** A valuable source of information regarding your benefits is the City employees' newsletter, Berkeley Matters. You will find information concerning workshops, open enrollment, the Benefits Fair, and other special announcements about your benefits in this publication. Berkeley Matters is published every other Friday with every paycheck. It is available via the City's intranet (iCoBWEB) if you use a computer in the course of your job. If you do not have computer access, you will receive a paper copy with your paycheck.
- **Benefit Forms Kiosk in the Human Resources Department:** Most benefits forms and information are available in the reception area; some forms are also available at the Payroll Audit Division (2nd floor) or from your Departmental Payroll Clerk.
- **Benefit Providers:** See Contact Information at the end of this book for a list benefit providers phone numbers.

Note: *Some benefits are based on Union representation. Please consult your Union's Memorandum of Understanding (MOU) or Memorandum Agreement (MA) to determine your specific benefits. Unrepresented employees should refer to the Unrepresented Employees Manual.*

Medical

Medical Plan Costs

In 2020, the City of Berkeley will spend an estimated over $16 million on health benefits for its members and dependents. Here are things you can do to help contain healthcare costs.

Stay Healthy

- **Quit smoking.** According to the Surgeon General, quitting smoking is the single most important step a smoker can take to improve the length and quality of life.
- **Manage your stress.** Take advantage of stress reduction resources offered through your workplace, health plan, and community.
- **Get more exercise.** Incorporate 30 minutes of moderate exercise, such as walking, into your daily routine.
- I**mprove your diet.** Eat more fruits, vegetables, and whole grains. Eat less sugar and saturated fat (red meat, dairy). Eliminate trans fats and fried foods.
- **Avoid heavy use of alcohol.** Drink no more than 1 drink per day for women and 2 drinks per day for men.
- **Know your numbers.** Get regular check-ups and preventative screenings as recommended. Normal preventive screenings are covered at no cost to you under the health plans.
- **Help manage your own health.** Keep track of your health concerns. Write them down; do not forget to discuss with your doctor.
- **Follow doctor's orders.** Work together to speed recovery or manage a condition.
- **Get an assessment of your health risks.** Complete a biometric screening and health risk assessment to identify your health status and risks. Share results with your doctor and discuss what steps you can take to reduce your risk.
- **Complete an Advance Directive.** You do not need a lawyer. Document your medical care wishes for your loved ones, in case you can't speak for yourself. https://oag.ca.gov/sites/all/files/agweb/pdfs/consumers/ProbateCodeAdvancedHealthCareDirectiveForm-fillable.pdf

Work With Your Doctor and Your Health Plan

- **Compare health plans.** Service areas, provider networks and out-of-pocket costs vary, but in most cases the City's medical plans provide the same benefits. Do your research and choose the plan that's best for you.
- **Wellness education.** Your plan and/or medical group may offer free or low cost fitness seminars or classes on wellness-related topics.
- **Generic drugs, by mail order.** Take advantage of your plan's reduced costs for generic and mail order prescriptions.
- **E-mail your doctor.** Make use of any online tools provided by your doctor's office for communicating concerns or appointment scheduling. Some doctors may also schedule telephone consultations.
- **Pay attention to appointment reminders.** Don't skip appointments. If you must cancel, notify your doctor's office in advance.
- **Outpatient surgery.** When possible, your doctor may schedule you to have surgery on an outpatient (non-hospitalized) basis.
- **Chronic condition management programs.** These services can help you and your family become better educated and coordinate care for diabetes, asthma, heart health, cancer, obesity and other conditions.

Medical (continued)

Health Insurance Options

Health insurance is often taken for granted. It's one of those benefits which we often don't really appreciate until we need it. The City offers a choice of three different health plans: three HMOs (Health Maintenance Organizations): two with Kaiser Permanente and one with Sutter Health Plus.

An HMO provides a wide range of health care services using a managed care approach. When you enroll in an HMO, you must use providers who are affiliated with the HMO. You do not have to complete claim forms, but certain services may need to be pre-authorized.

For most employees, the City pays the full premium for full-time employees and eligible dependents up to the Kaiser Permanente rate. Most employees enrolled under the Sutter Health Plus are required to pay the difference between the Kaiser Permanente rate and Sutter Health Plus HMO plans.

Medical premiums are deducted before taxes under the City's **IRS Section 125 Pre-Tax Premium Plan.** You are automatically enrolled in this plan when you sign up for health insurance. If you pay health insurance deductions, you are subject to certain regulations that allow you to have this benefit. One of these regulations state that **you may only enroll or withdraw from a health plan during the annual open enrollment period or when there is a change in family status.**

Kaiser Permanente

Kaiser Permanente is one of the oldest HMOs in the country, as well as one of the largest. Kaiser Permanente operates its own facilities and hires all physicians directly. There are a number of different Kaiser Permanente hospitals and medical centers in this area. Most services are provided at little or no cost to the enrollees. Under most circumstances, you must use Kaiser Permanente facilities and physicians, although emergency care is covered when you are away from home.

For more information about the Kaiser Permanente Plan, see the Kaiser Permanente Brochures, or contact Kaiser Permanente Member Services at 800.464.4000.

Sutter Health Plus

Sutter Health Plus HMO is affiliated with the Sutter Health organization. Many of Sutter Health's hospitals, physician organizations, surgery centers, outpatient sites, urgent care centers and other health care services are available through the HMO plan. To enroll in the plan, you must complete an enrollment form and select a Primary Care Physician. The Primary Care Physician will oversee all of your medical care. Other providers and specialists must be referred by your Primary Care Physician. You may change to a different Primary Care Physician whenever you choose. You may call Sutter Health Plus member services at 855.315.5800 or go online at www.sutterhealthplus.org/members to change physicians, to learn more about the services and facilities available.

For more information, see the Sutter Health Plus Brochures or call Sutter Health Plus Member Services at 855.315.5800.

Medical (continued)

Your Responsibilities

There are certain regulations that apply to the health and dental plans:

- **Enrollment:** You must complete an enrollment form for Kaiser Permanente or Sutter Health Plus. A verbal request for coverage is not sufficient, even if you were previously enrolled. If your coverage has been cancelled due to a leave of absence, you must complete an enrollment form and return it to the Payroll Audit Division (2nd floor) within 30 calendar days of eligibility (return from leave without pay). If you are covered under another plan such as a spouse's plan, and lose that coverage, you have 30 calendar days to enroll in a City health plan. Otherwise, you will have to wait until the Open Enrollment period.
- **Dependents:** You may only add new dependents to your health and dental coverage by completing the Kaiser, Sutter Health Plus and Delta Dental enrollment forms and returning them to the Payroll Audit Division (2nd floor) within 30 calendar days of birth, adoption, marriage, or completion and approval of a Domestic Partner Affidavit. Otherwise, you will have to wait to enroll them until the next Open Enrollment period. There are no exceptions!
- **Dependent Coverage:** Dependent children are covered until the age of 26, provided you claim them on your Federal tax return.
- **Domestic Partners:** You may add a domestic partner provided you meet all the conditions required by the City. In order to apply, you must file an Affidavit of Domestic Partnership with the Human Resources Department.
- **Termination of Coverage:** If you are legally separated, divorced or have dependents who are no longer eligible, they must be dropped from the City's group plan. If you terminate a domestic partnership, you must complete a Termination of Domestic Partnership Form and return it to the Payroll Audit Division (2nd floor) to remove your domestic partner from your medical/dental coverage. It is your responsibility to inform the City within 30 calendar days when a legally separated or divorced spouse, dependent or domestic partner is no longer eligible. Deleted dependents and domestic partners may continue to pay for their own premiums under the COBRA law (see page 30). Under the City's pre-tax premium plan, you cannot delete a dependent who is still eligible except during the annual open enrollment or when there is a change in family status.
- **Legally Separated/Divorced Spouses:** The City cannot cover former spouses even if you have a Court Order directing you to provide health insurance for your former spouse. The only time the City covers a legally separated/divorced spouse is if there is a court order directly ordering the City to provide coverage for that person. The cost to cover a former spouse under a court order is paid by the employee.

Cash-in-Lieu

If you have health and/or dental insurance coverage under another group plan, for example through your spouse, you have another option. You may apply for a cash payment in lieu of having the City pay health and/or dental insurance for you. Refer to your Memo of Understanding (MOU) for the specific health cash-in-lieu amount. The amount of the benefit for dental coverage is $61.64 per month. The amounts are pro-rated for eligible part-time employees. The cash-in-lieu payment is taxable and paid once a month on your paycheck.

You may only apply for cash-in-lieu within 30 calendar days of your hire date or during the annual Open Enrollment period. To be eligible for this benefit, you must complete the Cash-in-Lieu Form and provide evidence of your alternative coverage (letter or membership card). The form is available in the Human Resources Department and is provided to you when you are hired.

Medical (continued)

Medical Plans At-a-Glance

Schedule of Benefits	Kaiser Permanente		Sutter Health Plus
	HMO	HMO-HSA*	HMO
Effective Date	1.1.2020	1.1.2020	1.1.2020
Benefit Summary	All employees	All employees	All employees
General Plan Information			
• Annual Deductible			
– Individual	$0	$2,700	$0
– Family	$0	$5,450	$0
• Coinsurance	100%	100%**	100%
• Office Visit/Exam	$0	100%**	$10 copay
• Outpatient Specialist Visit	$0	100%**	$10 copay
• Annual Out-of-Pocket Limit			
– Individual	$1,500	$2,700	$1,500
– Two-Party	$1,500/member	N/A	$1,500/member
– Family	$3,000	$5,450	$3,000
• Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited
• Primary Care Physician Election Required	Yes	Yes	Yes
Inpatient Hospital Services			
• Inpatient Hospitalization	100%	100%**	$250 copay per admission
• Semi-Private Room & Board *(including Services and Supplies)*	100%	100%**	$250 copay per admission
Emergency Services			
• Emergency Room	$35 copay, waived if admitted	100%**	$100 copay, waived if admitted
• Ambulance	100%	100%**	$100/trip
Outpatient Care			
• Outpatient Services	100%	100%**	$10 copay
• Outpatient Detoxification Services	100%	100%**	$10 copay
Prescription Drug Benefits			
• Deductible	$0	100%**	$0
• Retail			
– Generic	$5 copay	100%**	$10 copay
– Brand *(Formulary/Preferred)*	$5 copay	100%**	$30 copay
– Brand *(Non-Formulary/Non-Preferred)*	$5 copay	100%**	$30 copay
– Specialty/30 Day Supply			20% coinsurance up to $250 per prescription
– Number of Days Supply	100 days	100%**	30 days
• Mail Order Mandatory	N/A		N/A
– Generic	$5 copay	100%**	$20 copay
– Brand *(Formulary/Preferred)*	$5 copay	100%**	$60 copay
– Brand *(Non-Formulary/Non-Preferred)*		100%**	$60 copay
– Number of Days Supply	100 days	100 days	100 days
Other Services and Supplies			
• Chiropractic Services	N/A	N/A	$15 copay up to 20 visits

* HMO-HSA plan is not available for all employees

** 100% covered after deductible is paid

The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the contract, the contract will prevail.

Dental

Basic Benefits

The City provides group dental benefits through Delta Dental of California for all benefit-eligible employees (their spouse or domestic partner, and any IRS dependent up to the age of 26).

Under this dental program, you may use any dentist you wish. If you choose a dentist who is not contracted with Delta Dental, you may be subject to any difference in fee rates that are set by Delta Dental. Click on the link below for more information:

- Delta Dental Plan Online Guide

How to Use the Delta Dental Program

To use this plan, just call the dental office of your choice and make an appointment. If you go to a Delta Dental dentist, their office will have Delta Dental claim forms to complete and submit to Delta Dental for you.

The Delta Dental Program allows you to:

Change dentists at any time without pre-approval.

- Go to a specialist of your choice without pre-approval.
- Have each member of your family go to a different dentist.
- Receive dental care anywhere in the world.

Give your dentist the following information: Your Social Security Number and group number as follows:

Group	Group Number
Police Officers	8367-17
Firefighters	8367-17
Electricians	8367-15
Confidentials & Executive Management	8657-17
All Other Employees	8367-12

Delta Dental pays the dentist directly. You are only responsible for your share of the bill. Your Delta Dental dentist may not charge you for amounts payable by Delta Dental. If you go to a non-Delta Dental dentist, you are responsible for the dentist's entire bill and Delta Dental will reimburse you directly.

Enrolling in the Delta Dental Plan

You will be given a dental enrollment card to complete when you are hired with the City. If for any reason you do not choose to enroll within 30 calendar days of your hire date, you will have the option to enroll during the annual Open Enrollment period. In addition, if you have not added dependents within 30 calendar days of eligibility, you may also add them during this period.

Benefit Structure

Benefits vary depending on your Union Agreement. Delta Dental covers 90% of the "usual, customary, and reasonable" charges (100% for employees represented by IBEW, Local 1245).

Maximum benefits are as follows:

- $4,000 annually for employees represented by IBEW, Local 1245.
- $3,000 annually for employees represented by BPA, BFFA Local 1227, Local One, Unrepresented Executive Managers.
- $2,000 annually for all other eligible employees.
- 90% of Delta Dental dentist's fees (100% for IBEW, Local 1245).

Orthodontic Benefits

- $4,000 lifetime for employees represented by IBEW, Local 1245.
- $3,000 lifetime for employees represented by BPA, BFFA Local 1227, Local One, Unrepresented Executive Managers.
- $2,000 lifetime for all other eligible employees.

Dental (continued)

Diagnostic and Preventive Benefits

- **Oral examinations:** two per year (three for employees represented by IBEW, Local 1245)
- **Prophylaxis (cleaning):** two per year, three for pregnant women (three for employees represented by IBEW, Local 1245)
- **X-rays:** every two years
- Fluoride treatments
- Space maintainers
- Specialist consultation
- Basic benefits
- Oral surgery
- Restorative treatments (fillings)
- Endodontics (root canal therapy)
- Periodontics (treatment of gums and bones supporting teeth)
- Sealants (children to age 14)
- Crowns, Jackets, and Cast Restorations are covered benefits only if they are provided to treat cavities that cannot be restored with amalgam, synthetic, plastic, or resin fillings; once every five years per tooth
- Prosthodontia benefits
- Bridges (fixed and movable)
- Full or partial dentures
- Dental implants

For more information about your benefits, click on one of the links below:

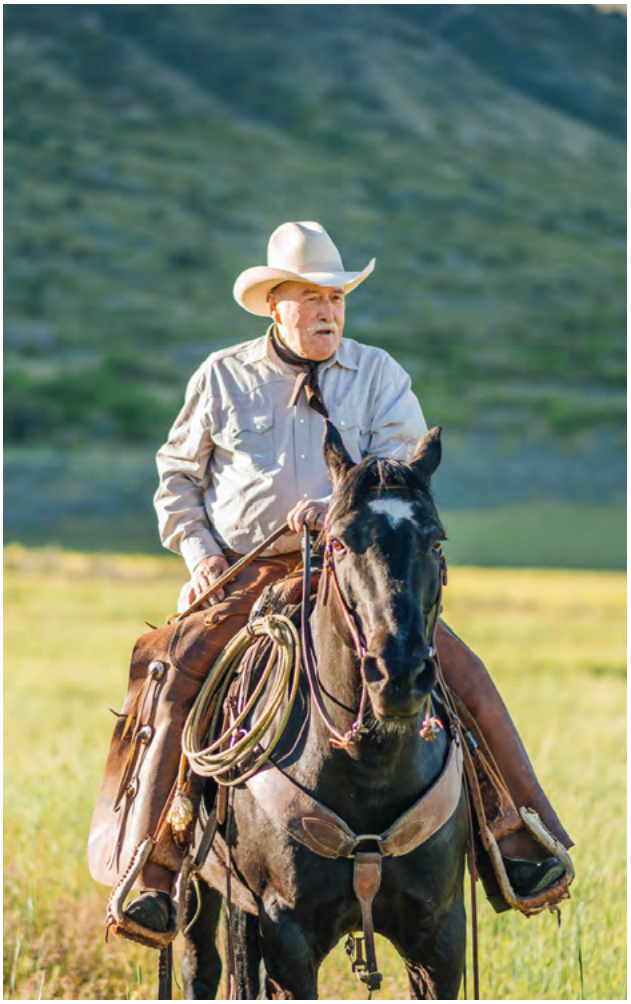
- **All Other Employees:** http://video.deltadentalins.com/videoplayer/97617_City_of_Berkeley_all
- **IBEW:** http://video.deltadentalins.com/videoplayer/97617_City_of_Berkeley_electrical

Choosing a Dentist

You may choose any licensed dentist. However, Delta Dental dentists offer the following:

- Delta Dental dentists will provide claim forms and complete them at no charge.
- When you go to a Delta Dental dentist, you only have to pay the amount of the copay, plus any deductibles that may apply. You will never have to pay the whole bill and then wait for reimbursement.
- If you go to a non-Delta Dental dentist and their fees exceed the "usual, customary and reasonable" (UCR) charges for your area, you may have to pay the excess over UCR charges plus your regular copay.

Call Delta Dental at 888.335.8227 with any questions or for a list of dentists in your area.



Dental (continued)

Dental PPO Plans At-a-Glance

Schedule of Benefits	Delta Dental of California					
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Effective Date	1.1.2020		1.1.2020		1.1.2020	
Benefit Summary	All other employees		Electricians		Police Officers, Firefighters, Confidential and Executive Management, Local One	
General Plan Information						
• Annual Deductible	$15/member		$15/member		$15/member	
• Annual Plan Max	$2,000		$4,000		$3,000	
• Lifetime Orthodontia Plan Max	$2,000/member; see plan certificate		$4,000/member; see plan certificate		$3,000/member; see plan certificate	
Covered Services						
• Diagnostic and Preventive Services	90% of **PPO** dentist approved fee	90% of **PREMIER** dentist approved fee	100% of **PPO** dentist approved fee	100% of **PREMIER** dentist approved fee	90% of **PPO** dentist approved fee	90% of **PREMIER** dentist approved fee
• Basic Services						
– Basic	90% of **PPO** dentist approved fee	90% of **PREMIER** dentist approved fee	100% of **PPO** dentist approved fee	100% of **PREMIER** dentist approved fee	90% of **PPO** dentist approved fee	90% of **PREMIER** dentist approved fee
– Endodontic Treatment	90% of **PPO** dentist approved fee	90% of **PREMIER** dentist approved fee	100% of **PPO** dentist approved fee	100% of **PREMIER** dentist approved fee	90% of **PPO** dentist approved fee	90% of **PREMIER** dentist approved fee
– Periodontic Treatment	90% of **PPO** dentist approved fee	90% of **PREMIER** dentist approved fee	100% of **PPO** dentist approved fee	100% of **PREMIER** dentist approved fee	90% of **PPO** dentist approved fee	90% of **PREMIER** dentist approved fee
• Major Services	90% of **PPO** dentist approved fee	90% of **PREMIER** dentist approved fee	100% of **PPO** dentist approved fee	100% of **PREMIER** dentist approved fee	90% of **PPO** dentist approved fee	90% of **PREMIER** dentist approved fee

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Vision

Vision Service Plan (VSP) – IBEW Local 1245 Only

This plan has a list of providers, both optometrists and ophthalmologists. If you use VSP providers, your costs for most services and materials are limited to the applicable copays.

Plan Features	Vision Benefits	
	In-Network Providers	Out-of-Network Providers
Effective Date	1.1.2020	
Annual Deductible *(Individual & Family)*	None	
Annual Out-of-Pocket Expense Limit/Person	None	
Lifetime or Other Maximums	None Maximums apply to the amounts the plan will reimburse for services and materials obtained out of network. If you stay in network, coverage of frames and elective contact lenses is limited to plan allowances.	
Frequency		
• Eye Exam	Once every 12 months	
• Lenses	Once every 12 months	
• Frames	Once every 24 months	
• Contact Lenses	Once every 12 months instead of lens benefits	
Plan Benefits		
• Vision Exam	Plan pays 100% after $25 copay	Up to $50 after $25 copay
• Single Vision Lenses	Plan pays 100% after $25 copay	Up to $50 after $25 copay
• Bifocal	Plan pays 100% after $25 copay	Up to $75 after $25 copay
• Trifocal	Plan pays 100% after $25 copay	Up to $100 after $25 copay
• Lenticular	Plan pays 100% after $25 copay	Up to $125 after $25 copay
• Contact Lenses		
– Elective	Up to $130 (in lieu of the other lens and frame benefit) after a $25 copay; allowance applied to cost of contacts, fees, evaluation and fitting	Up to $105 (in lieu of other lens and frame benefit) after $25 copay; allowance applied to cost of contacts, fees, evaluation and fitting
– Necessary	Covered in full	Up to $210 (in lieu of the other lens and frame benefit)
• Frames	VSP's plan allowance covers a wide selection of frames. If you choose a frame valued at more than the plan's allowance, the difference you will pay will be based on VSP's low, discounted member pricing.	Up to $70 after $25 copay

The above information is intended as a benefit summary only. It does not include all of the benefit provisions, limitations and qualifications. If this information conflicts in any way with the contract, the contract will prevail.

Life Insurance/AD&D

Basic Benefits

The City provides Group Life Insurance and Accidental Death & Dismemberment (AD&D) benefits through Hartford. Basic coverage is paid by the City and coverage amounts vary depending on your Union Agreement.

- $25,000 Life/AD&D coverage amount for employees represented by SEIU Local 1021 Maintenance and Clerical, Unrepresented Employees.
- $50,000 Life/AD&D coverage amount for employees represented by Local One, SEIU Local 1021 Community Services Unit.
- $100,000 Life/AD&D coverage amount for employees represented by BPA, BFFA Local 1227, IBEW Local 1245, and certain unrepresented employees.

If you die while actively employed with the City, your beneficiaries will receive a cash benefit. There is also a living benefit option that provides payment of a partial benefit for a terminally ill, insured employee.

If death is accidental, your beneficiaries will receive a matching amount under the AD&D coverage. AD&D also provides an equivalent benefit for the loss of both arms, both legs, or both eyes in an accident. Should you lose one arm, one leg, or one eye, your AD&D benefit will be one-half this amount.

Eligibility/Enrollment

You are automatically enrolled in the basic group life and AD&D insurance when you are hired by the City as a fully benefited (whether part-time or full-time) employee. You are covered as long as you are receiving a paycheck. If you are on leave of absence without pay (LWOP) for two consecutive pay periods or more (160 consecutive hours), your benefit stops unless you choose to continue paying the premium yourself. If you wish to do this, you must contact the Payroll Audit Division (2nd floor). When you return from LWOP, your life and AD&D insurance will be automatically reinstated.

Beneficiaries

When you are hired by the City, you are asked to complete a Beneficiary Designation Form. You can designate anyone as your beneficiary. You may change your beneficiary at any time by completing a new form, and returning it to the Human Resources Department.

If you die while still employed with the City and you did not have a beneficiary on file, the life insurance company will pay benefits in the following order: (1) your spouse, (2) your children, (3) your parents, or (4) your estate.

Waiver of Premium

If you have been disabled for nine continuous months, and you are under the age of 60, you may qualify for the Waiver of Premium benefit under the Life policy. "Disabled" means **total disability of a permanent nature**. The advantage to you is that you would continue to be covered for the remainder of your life without having to pay any more premiums after nine months of continuous disability.

In order to be eligible for the waiver of premium, you must provide the insurance company with proof of your disability within 12 months of first becoming disabled, and every 12 months thereafter. For more information, contact the Human Resources Department.

Optional Supplemental Life Insurance

You may also purchase additional Term Life Insurance coverage for yourself in units of $10,000, to a total maximum benefit of $300,000 or five times your annual salary, whichever is less (coverage may be reduced at age 70; consult the Human Resources Department for details). Coverage is normally subject to medical underwriting. New employees can apply for up to $100,000 within 30 days of hire date and all employees can apply for coverage during the annual open enrollment period. Medical approval may be necessary.

Spouse and/or dependent coverage for Supplemental Life is not available.

Life Insurance/AD&D (continued)

Supplemental Life Insurance Cost

Coverage cost varies with age. Your monthly premium will not change until the plan anniversary date following the year in which you move to a new age bracket. Premiums per each $10,000 unit are listed below.

The chart shows the current rates and are subject to change.

Age	Cost per $10,000
Under 30	$1.19
30 - 34	$1.54
35 - 39	$1.90
40 - 44	$2.62
45 - 49	$4.42
50 - 54	$6.59
55 - 59	$9.33
60 - 64	$11.32
65 - 69	$17.82
***70 - 74**	$30.76
***75 & over**	$30.76

* Benefit reduced by 67% at age 70; by an additional 45% at age 75.

Enrolling in the Supplemental Life Insurance

To be automatically eligible for the first $100,000 of supplemental life insurance coverage, you must enroll within 30 days of your hire date. New employees can also apply for higher amounts of supplemental coverage to a maximum total of $300,000 or five times your annual salary (whichever is lower), by completing a Personal Health Statement. You may obtain more information, as well as Enrollment/Evidence of Insurability Forms, from the Human Resources Department. Your coverage will become effective the first of the following month in which you are approved. Other benefited employees can apply for additional coverage during Open Enrollment.

Conversion and Portability (Termination of Employment)

You may convert and/or port your Basic Life or Supplemental Life Insurance to individual coverage when you terminate your employment with the City. You must apply within 30 calendar days of your termination date.

To obtain information about conversion and portability coverage, or if you have questions about applying for coverage, contact the Benefits Specialist in the Human Resources Department.

Flexible Spending Accounts

The Flexible Spending Accounts (FSAs) offer you a way to convert taxable salary dollars into tax-free benefit dollars you can use to pay health care expenses not covered by your medical, dental and vision plans. You may also use the FSAs to pay eligible child and dependent care expenses.

How FSAs Work

There are two Flexible Spending Accounts:

- Health Care Spending Account
- Dependent Care Assistance Program

During Open Enrollment, you decide how much you want to contribute to either or both accounts. You may contribute from $130 to $2,750 per year to the Health Care Account, and/or from $130 to $5,000 per year to the Dependent Care Assistance Program (or up to $2,500 if you are married and file separate tax returns). You cannot change your contribution amounts during the plan year unless you have a "qualified status change."

Your FSA contributions are deducted from your paycheck in equal amounts during the year. Because contributions are made before taxes are withheld, they are not subject to Social Security tax, federal income tax and, in most cases, state and local income taxes.

When you have an eligible expense, you submit a claim for reimbursement from the appropriate account. The Health Care Account and Dependent Care Assistance Program function separately. This means you cannot use health care funds to pay dependent care expenses and vice-versa.

IMPORTANT – Use It or Lose It!

The IRS has a strict "Use It or Lose It" rule that applies to the Flexible Spending Accounts. You must use the full amounts you deposit in each account to pay for eligible expenses you incur during the plan year or you will forfeit any remaining balance. You have a 2 1/2-month grace period (until March 15 of next year) to incur expenses and March 31 of the next year to submit claims for this year's expenses. Plan carefully!

Submitting Expenses

You should save all bills and receipts for eligible health care and dependent care expenses to use as proof of payment for reimbursement through the appropriate FSA. Claim forms can be obtained in the Human Resources Department.

Health Care Spending Account

You can use the Health Care Account to pay for eligible expenses for yourself and your dependents, even if your dependents are not covered under the City of Berkeley medical, dental and vision plans.

Eligible expenses include (but are not limited to):

- Medical, dental, vision and prescription drug expenses not covered by other insurance plans, such as deductibles, copays, amounts that exceed plan limits, hearing exams and hearing aids, chiropractic care and prescribed medical supplies and equipment, among others; ***and***
- Any other unreimbursed medical, prescription drug, dental or vision expenses allowed as a deduction by the IRS on your federal tax return (except insurance premiums).

Expenses that <u>are not</u> eligible include (but are not limited to):

- Health spa and club memberships, weight reduction or smoking cessation programs;
- Premiums for other health insurance coverage;
- Cosmetic surgery and other similar procedures;
- Non-medical expenses, such as electronic air filters and hot tubs, unless prescribed by a doctor; ***and***
- Over-the-counter (OTC) drugs.

Flexible Spending Accounts (continued)

Dependent Care Assistance Program

The Dependent Care Assistance Program (DCAP) is a tax-free salary set-aside program under Internal Revenue Code (IRC) Sections 125 and 129. It allows you to set aside from your salary up to $5,000 per year, **before taxes!**

Note: *If you are married but file a separate tax return, your maximum set-aside is limited to $2,500. Also, if your spouse is contributing to a Dependent Care Plan through his or her employer, your combined contributions cannot exceed $5,000.*

The plan year is the same as the calendar year. You may enroll within 30 calendar days of your hire date or once a year during the Open Enrollment period usually in November.

Who Benefits from DCAP?

You may benefit from DCAP if you have dependent care expenses that are incurred while you and your spouse are at work, such as:

- Expenses for the care of a dependent child (12 years or under)
- Expenses for the care of a dependent elder (if in your home at least 8 hours/day)
- Expenses for summer day camp or after school programs
- Housekeeping fees if part of the fee is for child care or elder care
- Expenses for the care of a physically or mentally disabled dependent

Remember, if you are married, both you and your spouse must be employed for you to take advantage of this benefit.

Exception: *If your spouse is a full-time student or disabled, you can set aside $2,400 for one dependent or $4,800 for two or more dependents per plan year.*

How does DCAP Work?

When you complete an Enrollment/Change Form, you decide how much money is to be set aside from each paycheck. To determine this amount, divide the total annual amount (up to $5,000) by 26 pay periods for the year. This amount is then deducted before taxes thereby reducing your Federal and State taxes. The amount set aside is placed in a reimbursement account for you to draw from for Dependent Care expenses throughout the plan year. All expenses to be reimbursed must be incurred during the plan year.

In order to be reimbursed for your salary set-aside, you must submit a claim form which can be obtained in the Human Resources Department.

Can I Benefit from DCAP?

For most employees with child care expenses, participation in the DCAP will yield more tax savings than the standard childcare credit. However, if you are uncertain, you may obtain a worksheet from American Fidelity to help you determine what works best for you.

How do I Enroll?

Enrollment Forms are available in the Human Resources Department or by calling American Fidelity. **You must enroll within 30 calendar days of your hire date or during the annual Open Enrollment which is commonly held in November. YOU MUST ALSO RE-ENROLL EVERY YEAR.** To enroll, complete an enrollment form and turn it in to the Human Resources Department.

Dependent Care Expenses Estimate

It is **very important** to be conservative in estimating the money you set aside for DCAP. **Under current laws, any money left in the account at the end of the plan year not claimed for employment-related Dependent Care expenses incurred during that plan year will be forfeited.** The balance **CANNOT** be carried over to the next plan year.

With proper planning, you can avoid forfeiture. You will have a 2 1/2 month grace period (March 15 of the next year) to incur expenses; claims must be received by March 31st of the next year. You will receive a quarterly statement of your account. Forfeited money is kept by the City as specified by IRS rules and will be used to lower future administrative costs for the plan.

Flexible Spending Accounts (continued)

Changes to Dependent Care Deduction

You should be aware that under most circumstances, the amount you elect to set aside for DCAP is set for the plan year. You may elect to increase, reduce, or stop DCAP deductions only at the time of the annual re-enrollment for the next plan year or if you have a "qualifying event."

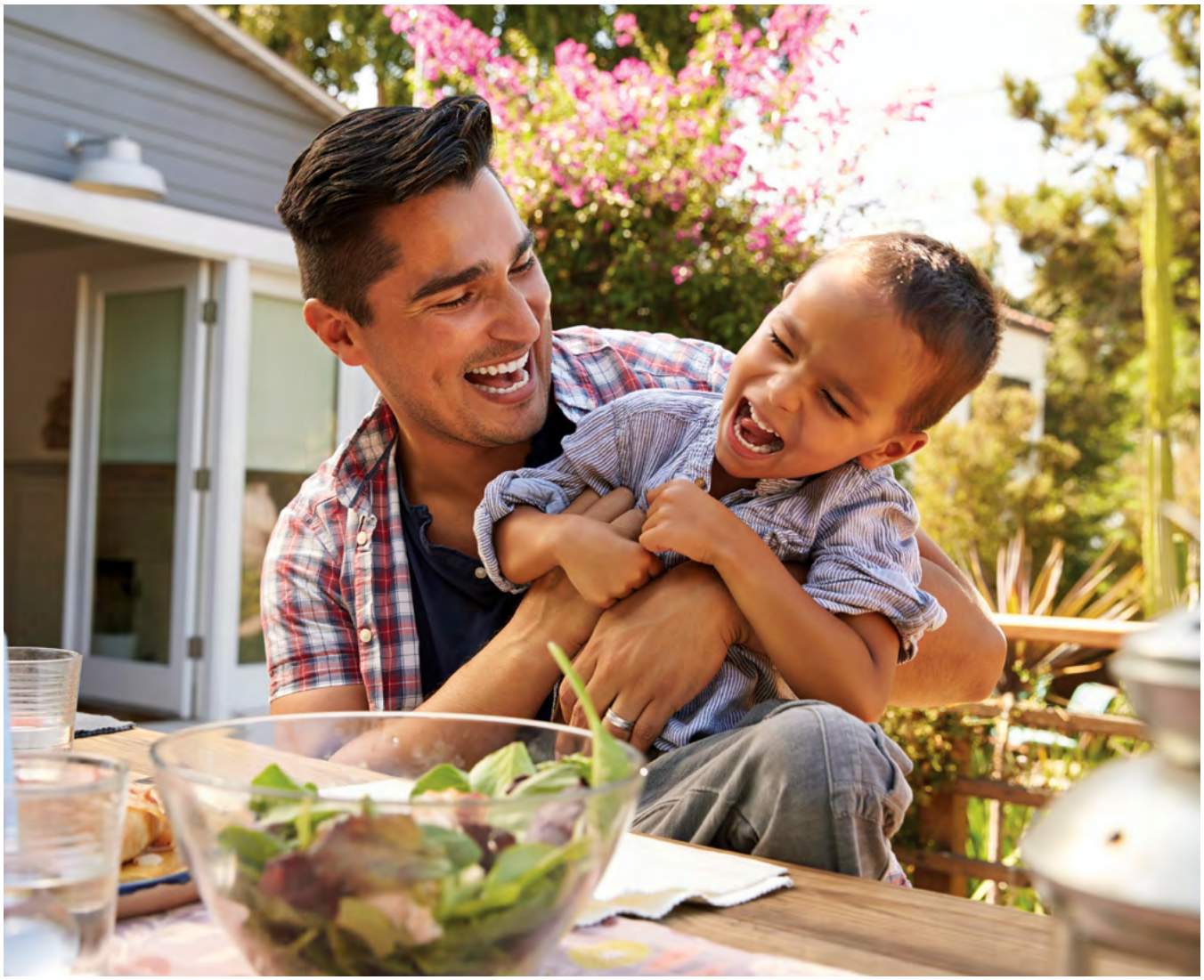
Exceptions: Qualifying Events

Once the plan year has begun, you cannot enroll, change the amount or drop out of the plan for that year unless you terminate employment or have a "qualifying change in family status." These IRS approved "qualifying events" include birth, death, adoption, marriage, divorce, loss of your spouse's employment or return to employment.

Termination of Employment

You have 90 days from the date you terminate to submit claims for dependent care expenses incurred while you were employed but not for expenses incurred after you are no longer employed.

To find out what types of expenses qualify under the DCAP, see IRS Publication 503 or review the Flexible Spending Account Information Sheet from the Human Resources Department.



Other Benefit Programs

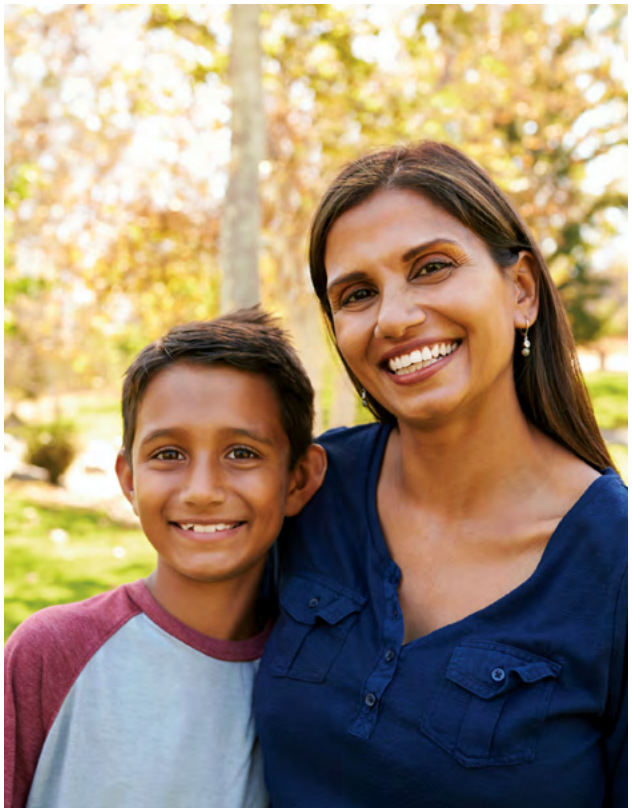
Employee Assistance Program

No one gets through life without problems. Each of us at one time or another faces hardship, tragedy, disappointment, or loss. The City offers an Employee Assistance Program (EAP) administered by Claremont Behavioral Services and provides a variety of professional counseling services for family, marital, financial, legal, emotional, stress or substance abuse problems. This program also provides consultation and referral services in tax preparation, child and elder care, and pre-retirement planning. You can even get a free copy of your credit report!

These services are entirely confidential and are free to employees and family members for up to a maximum of eight authorized sessions per incident per year.

If you are interested in using these services, you can call Claremont Behavioral Services at 800.834.3773. Additional information is available using the links below:

- Claremont EAP Brochure
- Video for Employees
- Training Video for Supervisors



VDT Eye Care Program

Personal computers play a significant role in the workplace for many City employees. Recent studies have shown that the lack of proper eyewear while using a computer video display terminal (VDT) can cause damage to our vision.

This is why the City has a VDT Eye Care program that provides eye examinations for employees who frequently work with personal computers. If corrective lenses are needed for use while working with VDTs, the City will pay for the eyeglasses to the maximum amount, as well as for the examination.

There is also a "Safety Glasses" component to this benefit. For more information, contact the Occupational Health & Safety Officer in the Human Resources Department at 510.981.6825.

For more information, you may obtain the VDT and Safety Glasses Request and Authorization Form from the Human Resources Department.

YMCA Membership

The Berkeley Downtown YMCA is across the street from the Martin Luther King Jr. Civic Center Building on Milvia Street. It provides a variety of recreational and health-related services including swimming, racquetball, dance and exercise classes, body-building and aerobic work-out rooms, including a Women's Fitness Center. The Y has expanded its facilities, including the addition of a beautiful new professional size pool. You may want to visit the YMCA and take a tour of these impressive new facilities. The City subsidizes the services for most employees by paying for 75% the membership fee. Employees who choose to join pay the remainder of the fee. Your participation is on your own time.

If you are interested in joining the YMCA, you can enroll at the Y office. There are variety of payment options. Be sure to show them your City I.D. card.

Note: *YMCA benefits are taxable.*

Disability Benefits

Disability can happen to anyone. A disabling illness or accident can strike when you least expect it. Disability benefits help maintain a portion of your income should you become unable to do your job.

Various types of disability benefits are available to you as a City employee depending on the type and severity of your disability. **Temporary disability** applies when you are disabled for a relatively short period of time and are able to return to your job. LTD and **disability retirement** cover you when you are permanently disabled or unable to work for an indefinite period of time.

Temporary Disability

State Disability Insurance (SDI)

SDI is employee-paid by payroll deduction. As of January 1, 2020, the SDI withholding rate is 1.0% of the first $122,909 of salary per year (subject to change annually) and a maximum benefit of $1,229.09 per week for up to a one year of disability if you are unable to work due to a non-work related accident or illness. The City will make up the difference between the amount paid by SDI and your regular salary with any available leave balances you have. SDI benefits are payable after a seven-day waiting period, contact the Payroll Audit Division (2nd floor) for more information. To file a disability claim go to the California Employment Development website, located at www.edd.ca.gov/disability/dihottofileaclaim.htm.

Note: *Sworn Fire and Police are NOT covered.*

Workers' Compensation

If you are injured on the job or have a work-related illness and are unable to work, you are covered by Workers' Compensation. The State of California regulations mandate that the City pay for medical costs for on-the-job injuries, as well as temporary disability benefits when you are unable to work. In addition, the City provides a generous salary continuation policy where we make up the difference between the temporary disability and your pre-disability net pay for up to one year, if you continue to be unable to work due to a work-related injury or illness.

Disability Benefits (continued)

Long Term Disability (LTD)

(SRIP II Participants)

The City provides a long term disability (LTD) plan for most employees hired on or after July 22, 1988, covered under the Supplementary Retirement and Income Plan (SRIP) II (exception: IBEW Local 1245 members may purchase optional employee-paid coverage).

The LTD benefit applies to employees who are either temporarily or permanently unable to perform the duties of the job classification. Approval of your claim will be based on medical verification. Benefits are payable after 90 days of disability (or if you are using your accrued sick leave during your disability, benefits are payable 90 days following the exhaustion of your sick leave). To apply for benefits, complete the Hartford Claim Packet or go to www.thehartfordatwork.com to initiate a claim, view medical underwriting status, set up direct deposit, or view claim payments. You may also obtain additional information in the Detailed Plan Description from the Human Resources Department.

Note: *LTD benefits are NOT available to Firefighters or Police Officers.*

LTD Coverage

- **Benefit:** 60% of your regular monthly earnings up to a maximum monthly benefit of $8,000; $100 minimum
- **Disability payments first two years:** The first two years, benefits are paid if you are unable to perform the essential duties of your own occupation due to accidental injury, sickness, mental illness, substance abuse or pregnancy.
- **Payments after two years:** After two years of disability, benefits will be paid if you are similarly prevented from performing any occupation for which you are reasonably suited.
- **Duration of benefits:** Benefits are payable as long as you are disabled or to age 65, if you become disabled before age 60. If you become disabled after age 60, benefits will be payable on a reducing time schedule.
- **Offsets to benefits:** Any disability benefits you receive from SDI, CalPERS, Workers' Compensation or Social Security will be deducted from your LTD benefit.

To apply for benefits, go to www.thehartfordatwork.com or you may obtain additional information from the Human Resources Department.

Family Medical Leave Act

The Family and Medical Leave Act of 1993 (FMLA) is a U.S. federal law requiring larger employers to provide employees job-protected unpaid leave due to a serious health condition that makes the employee unable to perform his or her job, or to care for a sick family member, or to care for a new child (including by birth, adoption or foster care). For further information, refer to Administration Regulation 2.4 on the Human Resources intranet.

California Paid Family Leave

There are times in the life of every working person when they need to care for a loved one. Maybe it's a working parent who needs more time to bond with and care for a newborn. Maybe it's an employee who needs to care for a seriously ill parent, child, spouse, or registered domestic partner. California's Paid Family Leave insurance benefit was created for times like these. This program is administered through the State of California's Employment Development Department. More information is available from the links below:

- Paid Family Leave Brochure
- Paid Family Leave Claim Form

Disability Benefits (continued)

SRIP I

The City provides a disability retirement plan for those participants of the Supplementary Retirement and Income Plan I (SRIP I) who are permanently disabled or disabled for an indefinite period of time. **This applies only to employees hired prior to July 22, 1988, and who have not elected to transfer to SRIP II**. A SRIP I disability applicant must be retired or terminated before he or she is eligible to receive benefits. **SRIP I participants must apply within one year from the last day worked** (SRIP I Plan Document, Section 4.36.703).

Coverage

- **Benefit:** 60% of monthly salary.
- **Definition of disability:** The same as CalPERS definition; that is, you are no longer able to perform the essential duties of your own occupation.
- **Duration of benefits:** Payable for life or until recovered from disability.
- **Offsets to benefits:** Any disability benefits you receive from SDI, Workers' Comp, or Social Security will be deducted from your SRIP I disability benefit.

How to Apply for SRIP I Disability

The City pays the SRIP I disability benefit. The City also contracts with MidAmerica, a Third Party Administrator (TPA) to administer the SRIP I disability plan. To apply for the SRIP I disability benefit, contact Human Resources. Your claim must be submitted within one year of the last date worked.

The TPA will make a recommendation to the Investment Plans (SRIP) Committee.

The SRIP Committee will review all relevant data, including the TPA recommendation, the CalPERS determination, and any other medical data they may have requested. Once the SRIP Committee makes a determination, a letter will be sent to the claimant.

If your claim is approved, you will receive a check each month from the TPA. Once approved, the SRIP I disability recipient will be asked to supply updated medical data to the City (or TPA) once a year per the SRIP I plan.

For more details regarding this benefit, see the SRIP I Ordinance #5450 (as amended).

Disability Retirement – CalPERS

If you are unable to perform your job because of an illness or injury which is expected to be permanent or to last indefinitely, you may be entitled to receive a monthly disability allowance under the California Public Employees Retirement System (CalPERS) for the rest of your life (or until you recover).

Eligibility

Any participant under CalPERS who has at least five years of credited service may apply for disability retirement. The disability can be either work related or non-work related. Safety Members (Sworn Fire and Police) may also apply for **industrial** (work-related) disability retirement.

Benefit

For most employees, the benefit is calculated based on the number of years of service credit you have times 1.8% of your salary. If you have more than 10 years, you will probably qualify for the maximum disability retirement benefit of 33.3% of salary.

If you are a Safety Member, the industrial disability retirement benefit is equal to 50% of your salary and is non-taxable.

How to Apply for CalPERS Disability

Obtain a CalPERS Disability Retirement Packet online or from either the Payroll Audit Division (2nd floor) or the Human Resources Department. Complete the CalPERS disability retirement application, release authorization form, and survivor continuance form included in the packet and mail them directly to CalPERS. Give the medical report form to your physician to complete and mail it to CalPERS. If you are age 50 or over, you may want to check the box which says "Service pending Disability Retirement." This way you will be assured of receiving whichever benefit is higher and will be able to begin receiving benefits sooner (determination of disability sometimes takes several months). If you are approved for disability retirement later, your benefit will be adjusted if necessary.

CalPERS will make a determination of disability based upon the medical evidence provided. In the case of Safety Members, the City makes the determination of disability.

Deferred Compensation

What is the Deferred Compensation Plan?

The City Deferred Compensation Plan is a great way to save for your retirement. In addition to the CalPERS and SRIP retirement plans which the City pays into for you, the Deferred Compensation Plan under IRC Section 457 allows you to deduct a portion of your pre-tax salary from your paycheck for you to invest in mutual funds and/or a fixed income account. The City has three providers to choose from: Mass Mutual, CalPERS 457 Plan and Prudential Investments. You can enroll with any of the three companies or even with two or three at a time.

Maximum Contributions

Under the Deferred Compensation Plan, you may defer up to a maximum amount set by the IRS ($19,500 in 2020) per year. However, in your last three years before retirement, you are allowed to contribute up to double the maximum per year ($39,000 in 2020) if you did not defer the maximum during previous years. To determine your eligibility as well as your allowable maximum, contact your provider or the Payroll Audit Division (2nd floor). If you're age 50 or older, you are allowed to make additional catch-up contributions as determined by the IRS ($6,500 in 2020).

Enrollment

You can sign up at any time by calling one or more of the providers and asking them to send you an information/enrollment kit. To assist you in deciding on contribution levels and fund choices, you can arrange for individual meetings with representatives from the different providers. You can follow the links below to the enrollment forms, which must be complete and return it to the Human Resources Department:

- CalPERS 457 Plan
- Mass Mutual 457 Plan
- Prudential 457 Plan

Contribution Changes

To change the amount you contribute (payroll deduction), you must complete a change form for either CalPERS, Mass Mutual or Prudential and return it to the Payroll Audit Division (2nd floor) the month prior to the effective date of the change. To transfer your funds from one provider to another, complete either the CalPERS, Mass Mutual or Prudential Transfer Form and return it to the Human Resources Department. Funds may be transferred from one company to another without any penalties or transfer fees.

Providers

To find out more about the Deferred Compensation Plan, contact any of the providers listed below.

Group	Phone Number
Mass Mutual 457 Plan – Dennis Duarte	800.835.8447
CalPERS 457 Plan – Nancy Garrity	888.713.8244, x2
Prudential 457 Plan – Bruce Stuart	415.693.6016

Note: *Fees are only one factor to consider when selecting a fund. Other considerations include long term performance and level of risk.*

It's advisable to examine the fund detail information or prospectus available from the provider.

What happens if I change employers or terminate before I retire?

You can withdraw your account balance in cash, subject to mandatory 20% Federal withholding tax, as well as state taxes. IRS 457 plans are not considered "qualified plans" and therefore there are no additional penalties for early withdrawal. You can also roll your monies into another 457 plan or into an IRA or other qualified plan. You can also leave it in until you reach retirement age.

Retirement

How to Apply for Retirement

When you reach retirement age, there are several different retirement options for you to choose from. Your CalPERS retirement benefit is based on a formula that takes into account your age, years of service, and highest year(s) salary and the CalPERS formula for which you are qualified. Should you become disabled prior to retirement age, you may be eligible for a disability retirement benefit.

To apply for CalPERS retirement, you should obtain a CalPERS Retirement Application Booklet online or from the Payroll Audit Division (2nd floor) or by contacting CalPERS. Section 7 - the "Employer Certification" is completed by the Payroll Audit Division. The completed application forms should be mailed directly to CalPERS.

Employees approaching retirement are encouraged to attend a CalPERS Retirement Planning Workshop. **You can call CalPERS at 888.225.7377 for details. The City also provides Retirement Workshops that cover the information found here about your other benefits in more detail. Watch for announcements about both of these workshops in Berkeley Matters.**

Sick Leave Options

If you have at least 20 years of service or are approved for job-related disability retirement, you have various options concerning your unused sick leave balance when you retire.

Note: Sick leave payout is automatic, unless the City receives official notification from the employee to apply the balance towards service credit.

- Employees eligible for sick leave pay can be paid 38% of unused sick leave, or 50% with at least 28 years (Safety employees should consult their Union Agreement for payout options). The remaining balance is reported to CalPERS by the Payroll Audit Division (2nd floor) for additional service credit.
- **All** of your sick leave balance can be reported to CalPERS for additional service credit (no payout or medical credit). **You must notify the Payroll Audit Division (2nd floor) in writing if you choose this option.** If you have less than 20 years of service, all of your leave will automatically be reported to CalPERS by the Payroll Audit Division (2nd floor) for service credit.
- **For Sworn Police Officers only:** You may choose to contribute to the PORAC Retiree Medical Trust. Refer to your M.O.U. for specific information about this option.

Retiree Medical

Who is Eligible?

Depending on your years of service and if you are age 55 or older, you may be eligible for contributions as specified under your specific Retiree Health Premium Assistance Plan. In general, contributions are made by the City for you to pay a portion of your retiree medical insurance coverage (safety members refer to your MOU).

What is the Benefit?

The City pays a retiree medical subsidy that can be used for health insurance premiums of the retiree (single-party) or retiree and spouse/domestic partner (2-party). The amount of the City's contribution is defined in each of the various Memorandum Agreements or Memorandum of Understanding. Please contact Human Resources for your specific subsidy amount.

Retirement (continued)

How To Enroll

Two months before you plan to retire, you should contact the Human Resources Department to enroll in the Retiree Health Premium Assistance Plan. If the amount of your premium is more than the amount of the City's monthly contribution, you are required to pay the difference. If you enroll in a City group plan, the amount you are responsible to pay can be automatically deducted from your CalPERS retirement check. You will need to complete a Retiree Health Premium Assistance Plan Enrollment Form, a Kaiser or Sutter Health Plus Enrollment Form, and a CalPERS Authorization of Deduction Form and return them to Human Resources. The City has hired BASIC Pacific to administer these benefits.

If you choose not to enroll right away when you retire you **must maintain continuous coverage** elsewhere until you are ready to enroll. If you are at least 50 years of age, but less than 55, or if you retire with a CalPERS approved disability retirement at any age, you may be eligible for Retiree Medical benefits at age 55 **provided that** you maintain continuous coverage until age 55.

Medicare Plans

When you are 65 and eligible for Medicare, the amount that the City pays towards the Retiree Health Premium Assistance Plan is greatly reduced for most employees. If you choose to enroll in a Medicare supplement plan, the City's group plan option is Kaiser Permanente's Senior Advantage Plan. Kaiser Permanente sponsors workshops that offer information about this plan. Currently, Sutter Health Plus does not offer any Medicare supplement plan options.

If you do not wish to enroll in the City's group plan option, you may contact FuturisCare at 888.616.7130 for assistance in finding a plan that meets your needs or you may explore other options available on the California Exchange (Covered California). For eligibility and restrictions in applying the City's contribution towards an outside plan, please contact Human Resources at 510.981.6800.

SRIP and Deferred Compensation Withdrawal Options

There are several ways you can receive your SRIP and Deferred Compensation funds when you retire. You may request a cash lump sum payment, an annuity, systematic withdrawal (monthly or annual payments until the balance is exhausted), or you can roll your funds into an IRA. SRIP withdrawal forms for Mass Mutual (SRIP II/III), and Prudential (SRIP III); Prudential SRIP II withdrawal requests may be completed online. More detailed information is available in the Human Resources Department. The completed forms should be returned to the Human Resources Department. You should contact your Deferred Comp representative for information about retirement options and to obtain the proper forms for CalPERS, Prudential, and Mass Mutual. Call 415.766.1649 for Mass Mutual, 800.347.3488 for Prudential, and 888.713.8244 for the CalPERS 457 plan.

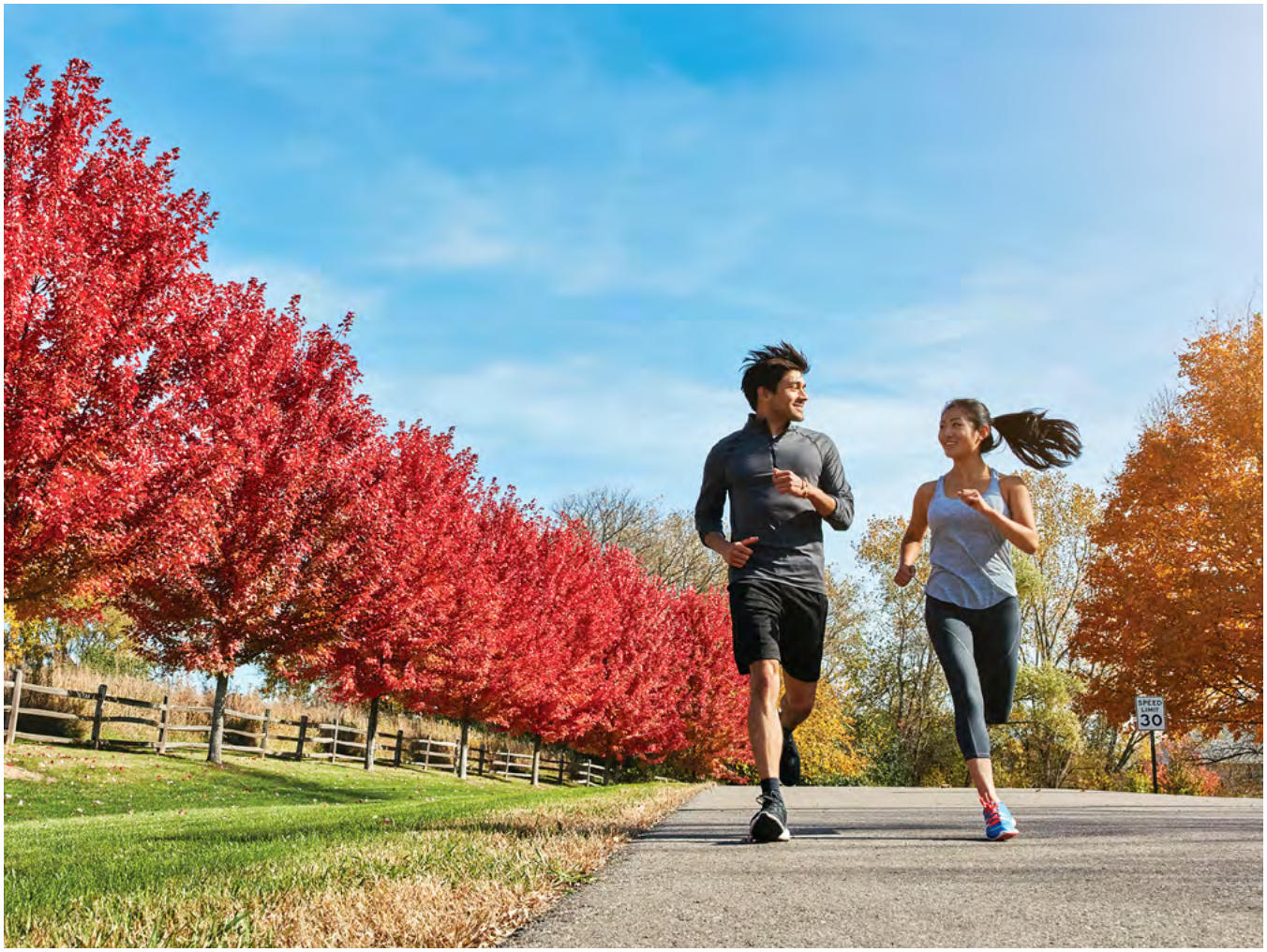
Working after Retirement

You may not be employed by any State agency or public agency covered under CalPERS, except as a non-benefited employee up to a maximum 960 hours allowed per year. You may work for a non-CalPERS employer; however, any **disability** retirement benefits you are receiving from CalPERS may be reduced.

Other Benefits

- **Dental Insurance** may be extended for up to 18 months under Federal COBRA regulations. There is no group dental coverage strictly for retirees. Contact the Payroll Audit Division (2nd floor) regarding COBRA coverage.
- **Life Insurance**, both group and optional life, may be converted to individual coverage. Rates will vary depending upon your age and state of health. You must apply within 30 calendar days of termination. Contact the Human Resources Department for more information.

CalPERS



Public Employees Retirement System

Each pay period, the City contributes a percentage of your salary into the CalPERS retirement fund. In addition to the employer's share, the City also pays the employee's contribution (8% after January 5, 2003, for eligible employees except sworn Public Safety members) or the percentage allowed by CalPERS based on employee's retirement formula. Safety members pay a 9% contribution from salary on a pre-tax basis. The employee's contribution goes directly into an employee's account and can be withdrawn prior to retirement. The employee does not benefit from the employer's contribution unless he or she retires.

"Vested" means that you have at least five years of full-time CalPERS service and will be eligible for retirement age at the minimum age of 50, or if you've been a member or after January 1, 2013, you must be at least age 52. If you leave the City before you reach retirement age, you may elect to leave your money with CalPERS (provided you are vested) or withdraw your portion. The City's contribution remains with CalPERS. If you work for another California public employer, you may be able to combine that agency's retirement benefit with CalPERS. Check with your new employer to see if their retirement system has "reciprocity" with CalPERS. For information regarding CalPERS, refer to the CalPERS website for members or call CalPERS at 888.225.7377.

SRIP

Supplementary Retirement and Income Plan

In 1982, the City's miscellaneous employees elected to withdraw from participation in the Federal Social Security system. In its place, the City contributes into a special City plan called the Supplementary Retirement and Income Plan (SRIP).

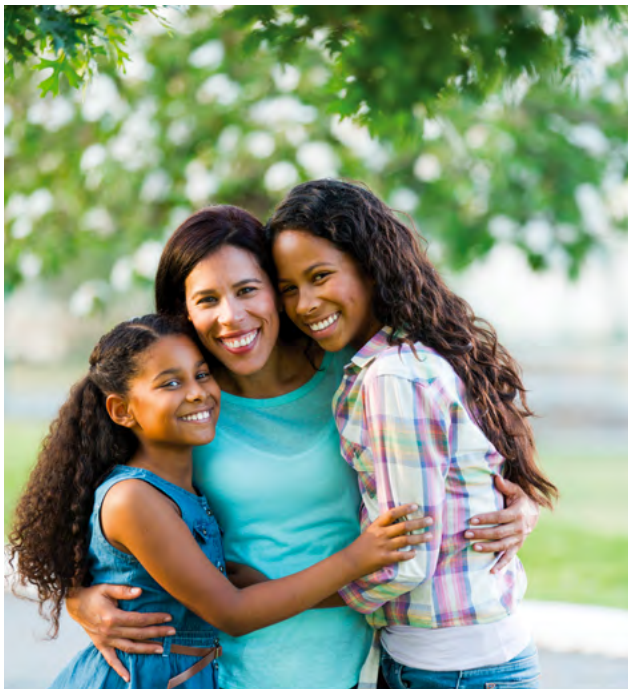
Note: *Fire Fighters do not participate in SRIP.*

SRIP I

Except for Safety members, employees who were hired before July 22, 1988 are in SRIP I (unless they have elected to move to SRIP II).

Contribution of 5.7% of first $32,400 in annual salary is paid into an individual Internal Revenue Code Section 401(a) retirement self-directed investment account by the City.

- 1% of salary, up to $32,400 annually, is paid into a disability plan by the City. Benefits equal 60% of salary less any benefits received under Workers' Compensation, Social Security Disability or State Disability if you are determined to be permanently disabled.
- Employee must be terminated or retired from the City in order to receive disability benefits. Definition of disability is the condition of mental or physical infirmity that constitutes total disability under CalPERS. Benefits are taxable and are paid for life or as long as you are disabled.



SRIP II

Miscellaneous employees hired after July 22, 1988 are automatically enrolled in SRIP II.

- Contribution of 6.7% of first $32,400 in annual salary (a maximum of $2,170) is paid into an individual Internal Revenue Code Section 401(a) retirement self-directed investment account by the City.
- LTD insurance is paid for by the City. Benefits equal 60% of salary less any benefits received from SDI, Workers' Compensation, Social Security, or CalPERS if employee is found to be either temporarily or permanently disabled. Benefits are payable after 90 days and employee does not have to be terminated from employment.
- The definition of disability is to be disabled from your own occupation for the first two years, and from any occupation for which you are reasonably suited after that. Benefits received are taxable and are payable for as long as you are disabled or to age 65, whichever comes first.

SRIP III

Berkeley Police Association members are automatically enrolled in SRIP III.

Contribution of 2% of first $32,400 in annual salary (a maximum of $648) is paid into an individual Internal Revenue Code Section 401(a) retirement self-directed investment account by the City.

Employees can choose between Mass Mutual and Prudential as their SRIP administrator. The SRIP toll-free number at Mass Mutual is 800.339.4015. The SRIP phone number with Prudential is 800.833.5761.

SRIP I, SRIP II or SRIP III

SRIP I participants may transfer to SRIP II at any time. Once an employee elects to transfer to SRIP II, he or she CANNOT transfer back to SRIP I. This is an irrevocable decision. SRIP III participants are employees represented by the Berkeley Police Association.

SRIP (continued)

SRIP Loans

Participants may borrow up to 50% of their account balance. There is a processing fee and the loans are repaid through payroll deductions. SRIP II and SRIP III participants are allowed to have two loans at the same time, provided there are sufficient funds in their account.

All SRIP forms, including loan applications, SRIP II transfer requests, and withdrawal requests are available in the Human Resources Department. Completed forms should be returned to the Human Resources Department.

Loan Applications

- **SRIP II/III –** Mass Mutual
- **SRIP II –** Prudential
- **SRIP III –** Prudential

Transfer Requests

- **SRIP II –** Mass Mutual
- **SRIP II –** Prudential

Withdrawal Requests

- **SRIP I/II/III –** Mass Mutual
- **SRIP III –** Prudential
  SRIP II and III withdrawal requests may be completed on the Prudential website; see page 28)

Beneficiary Forms

- **SRIP I/II/III –** Mass Mutual
- **SRIP II –** Prudential
- **SRIP III –** Prudential

Leaving the City

Termination Options

When you leave your employment with the City, there are a number of decisions to be made about your benefits. Be sure your payroll clerk has your correct address before you leave so that we can stay in touch with you regarding your benefits.

If your departure from City employment is not due to retirement, you may be eligible for COBRA Continuation Coverage for your health care benefits. Please refer to the following page for more information.

Retirement Plans

Withdrawal Options

Normally, you cannot withdraw your retirement funds while you are employed with the City. If you leave your employment with the City, you are entitled to whatever funds you have in your accounts. If you choose to withdraw your funds, they will be taxed in the year that they are withdrawn. CalPERS and SRIP are subject to a mandatory 20% Federal withholding tax (if you have an outstanding loan balance, that amount will also be taxable). If you withdraw funds from either of these accounts prior to retirement age 59 1/2, you may also be subject to additional penalties for early withdrawal. Deferred Compensation is also subject to the 20% Federal withholding tax when you withdraw it but is not subject to penalties for early withdrawal.

Rollovers

You may elect to roll the CalPERS, SRIP or Deferred Compensation funds over to an approved IRA (Individual Retirement Account), an IRS 401(a) qualified retirement plan, or an IRS 457 provided the plan accepts rollovers. When you roll the funds directly there will be no immediate tax consequences.

Retirement Savings

Of course you may leave your retirement funds in any of these accounts provided you have a minimum required balance or, in the case of CalPERS, if you have five years of credited service. The accounts will continue to accrue investment earnings for you until you reach retirement age. Once you reach age 70-1/2 you will have to take a "Required Minimum Distribution" from each of your accounts.

To find out about receiving your Deferred Compensation and SRIP funds, contact the Human Resources Department at 510.981.6800, or you may complete a withdrawal/distribution request using the links below:

Deferred Compensation

- CalPERS
- Mass Mutual
- Prudential

SRIP

- Mass Mutual
- Prudential (SRIP II) requests may be submitted online
- Prudential (SRIP III) requests may be submitted online

Forms are also available in the Human Resources Department.

CalPERS will contact you directly concerning your options once you have officially left employment with the City.

Other Benefits

Your life insurance coverage is eligible for conversion or portability within thirty days of termination. You may also convert your LTD coverage, provided you have at least one year of service and are not retiring. For more information, contact the Human Resources Department.

Important Notices

Statement of Belief – Grandfathered Status

The City of Berkeley believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, such as the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, such as the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator:

City of Berkeley
2180 Milvia Street
Berkeley, CA 94704
510.981.6800

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866.444.3272 or www.askebsa.dol.gov. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 510.981.6800 for more information.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact your carrier.

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

You do not need prior authorization from the plan or 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, please contact your carrier

Networks/Claims/Appeals

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

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under 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 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 does not accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than 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 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 (e.g., divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

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

Important Notices (continued)

NOTICE AND ELECTION PROCEDURES

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

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

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This disability would have to have started 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 COBRA CONTINUATION COVERAGE

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

Important Notices (continued)

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 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.

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

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

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

IF YOU HAVE QUESTIONS

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

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

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

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

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

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

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

For information about Special Enrollment Rights, please contact:

City of Berkeley
Human Resources Benefits
510.981.6800

Medicare Part D – Important Notice 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 The City of Berkeley 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:

- **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.**
- **The City of Berkeley has determined that the prescription drug coverage offered by the City of Berkeley 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 Berkeley coverage will not be affected. If you keep this coverage and elect Medicare, the City of Berkeley coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current City of Berkeley coverage, be aware that you and your dependents will be able to get this coverage back.

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 the City of Berkeley 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 (i.e., 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 will 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 the City of Berkeley 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 will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

Important Notices (continued)

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

REMEMBEREEP THIS CREDITABLE COVERAGE NOTICE. IF YOU DECIDE TO JOIN ONE OF THE MEDICARE DRUG PLANS, YOU MAY BE REQUIRED TO PROVIDE A COPY OF THIS NOTICE WHEN YOU JOIN TO SHOW WHETHER OR NOT YOU HAVE MAINTAINED CREDITABLE COVERAGE AND, THEREFORE, WHETHER OR NOT YOU ARE REQUIRED TO PAY A HIGHER PREMIUM (A PENALTY).

Date:	January 1, 2020
Name of Entity / Sender:	City of Berkeley
Contact:	Human Resources Benefits
Address:	2180 Milvia Street Berkeley, CA 94704
Phone:	510.981.6800

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

The City of Berkeley Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact the City of Berkeley, Human Resources Benefits, at 510.981.6800.

Important Notices (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about the City of Berkeley in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855.653.3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through Covered California is anticipated to begin October 15, 2020 and end on the following January 31. Open Enrollment for most other states will begin on November 1 and close on December 15 of each year.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.78% (for 2020) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

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

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

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

PART B: EXCHANGE APPLICATION INFORMATION

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855.653.3626 or at www.KeenanDirect.com.

3. Employer name City of Berkeley	**4. Employer Identification Number (EIN)** 94-6000299	
5. Employer address 2180 Milvia Street	**6. Employer phone number** 510.981.6800	
7. City Berkeley	**8. State** CA	**9. ZIP code** 94704
10. Who can we contact about employee health coverage at this job? Katherine Cabrera, Human Resources Office Specialist II		
11. Phone number (if different from above)	**12. Email address** kcabrera@cityofberkeley.info	

Important Notices (continued)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 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 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, 2019. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 855.692.5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866.251.4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855.MyARHIPP (855.692.7447)

COLORADO – Health First Colorado
Colorado's Medicaid Program & Child Health Plan Plus (CHIP+)
Healthy First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 800.221.3943
TTY: Colorado relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 800.359.1991
TTY: Colorado relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 877.357.3268

GEORGIA – Medicaid
Website: http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp/
Phone: 678.564.1162, ext. 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877.438.4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone: 800.403.0864

IOWA – Medicaid
Website:
http://dhs.iowa.gov/hawki
Phone: 800.257.8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 785.296.3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/agencies/dms
Phone: 800.635.2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 888.695.2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 800.442.6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 800.862.4840

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp | Phone: 800.657.3739

MISSOURI – Medicaid
Website:
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573.751.2005

Important Notices (continued)

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800.694.3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855.632.7633
Lincoln: 402.473.7000
Omaha: 402.595.1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov/
Medicaid Phone: 800.992.0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603.271.5218
Toll-Free for the HIPP program: 800.852.3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609.631.2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800.701.0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800.541.2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919.855.4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 844.854.4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888.365.3742

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 800.699.9075

PENNSYLVANIA – Medicaid
Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 800.692.7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855.697.4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 888.549.0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 888.828.0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 800.440.0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877.543.7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800.250.8427

VIRGINIA – Medicaid and CHIP
Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 800.432.5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 855.242.8282

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800.562.3022, ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 800.362.3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307.777.7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

Preventative Care Summary

	Children	Adult Women Age 18-49	Adult Men Age 18-49	Adult Women Age 50+	Adult Men Age 50+
Annual Wellness Exam *(check height, weight, blood pressure; assess tobacco and alcohol use, depression risk and other concerns)*	Yes, up to age 18	Yes	Yes	Yes	Yes
Abdominal Aortic Aneurysm *(one time screening)*					Yes, if ever smoked
Alcohol and Drug Use Assessment	For adolescents				
Autism Screening	For children at 18 and 24 months				
Behavioral Assessments	Different tests based on age; up to age 17				
Cervical Cancer Screening *(pap smear)*		Yes, every three years		Yes, every three years	
Cholesterol Screening		Yes, 20+ with heart disease or with risk factors for heart disease	Yes, 18-20 with heart disease or with risk factors for heart disease; or at age 35+	Yes, 50+ with heart disease or with risk factors for heart disease	Yes
Colorectal Cancer Screening		Yes, if high risk	Yes, if high risk	Yes, ages 50-75	Yes, ages 50-75
Development Screening	Yes, if under age three				
Diabetes Type 2 Screening *(for adults with high blood pressure)*		Yes	Yes	Yes	Yes
Dyslipidemia Screening	Yes, if at risk of lipid disorders				
Fluoride Chemoprevention Supplements	Yes, if no fluoride in water source				
Gonorrhea Prevention Medication	Yes, for eyes of newborns				
Hearing Screening	Yes, for newborns	Yes	Yes	Yes	Yes
Hematocrit or Hemoglobin Screening	Yes, up to age 4				
Hemoglobinopathies Screening *(sickle cell)*	Yes, for newborns				
Hypothyroidism Screening	Yes, for newborns				
Lead Screening	Yes, if at risk of exposure				
Mammography Screening *(breast cancer)*		Discuss with doctor when to start; up to age 49		Yes, every two years; ages 50-74	

Preventative Care Summary (continued)

	Children	Adult Women Age 18-49	Adult Men Age 18-49	Adult Women Age 50+	Adult Men Age 50+
Phenylketonuria Screening (PIU)	Yes, for newborns				
STI Screening *(sexually transmitted infection)*	Yes, for adolescents at higher risk	Yes, if at risk	Yes, if at risk	Yes, if at risk	Yes, if at risk
Tuberculin Testing	Yes, for children at higher risk				
Annual Flu Immunization	Yes	Yes, if at risk	Yes, if at risk	Yes	Yes
Hepatitis A Immunization	Yes	Yes, if at risk	Yes, if at risk	Yes, if at risk	Yes, if at risk
Hepatitis B Immunization	Yes	Yes, if at risk	Yes, if at risk	Yes, if at risk	Yes, if at risk
Herpes Zoster Immunization *(shingles)*			Yes, ages 60+; one time		Yes, ages 60+; one time
Human Papillomavirus Immunization	Yes	Yes, up to age 26			
Inactivated Poliovirus	Yes				
Measles, Mumps, Rubella Immunization	Yes	Yes, if no proof of immunity	Yes, if no proof of immunity	Yes, if at risk	Yes, if at risk
MMR Immunization *(measles, mumps, rubella)*	Yes, if no proof of immunity	Yes, if no proof of immunity	Yes, if at risk	Yes, if at risk	Yes, if at risk
TDAP/TD Immunization *(tetanus, diphtheria, whooping cough)*	Yes	Yes, every 10 years	Yes, every 10 years	Yes, every 10 years	Yes, every 10 years
Pneumococcal Immunization *(pneumonia)*	Yes		Yes, age 65 and up; sooner if high risk		Yes, age 65 and up; sooner if high risk
Rotavirus Immunization *(Intestinal tract virus)*	Yes				
Varicella Immunization *(chicken pox)*	Yes	Yes, if no proof of immunity	Yes, if no proof of immunity	Yes, if no proof of immunity	Yes, if no proof of immunity

Consult with your doctor about the types of screenings and immunizations that are right for you. This is a brief summary based on U.S. Preventive Services Task Force guidelines. For more details, visit:
www.healthcare.gov/preventive-care-benefits/| www.healthcare.gov/preventive-care-women/| www.healthcare.gov/preventive-care-children/

Vendors

Below is a listing of the toll-free numbers you can call with questions about the plans available to you. Watch Berkeley Matters for information, changes and deadlines connected to your benefits.

Benefit/Provider	Phone	Web Site
Medical		
• Kaiser Permanente	800.464.4000	www.kaiserpermanente.org
• Sutter Health Plus	888.315.5800	www.sutterhealthplus.org
Dental		
• Delta Dental	888.335.8227	www.deltadental.com
– Police Officers *(Group #8367-17)*		
– Firefighters *(Group #8367-17)*		
– Electricians *(Group #8367-15)*		
– Miscellaneous Employees *(Group #8367-12)*		
– Confidential & Executive Management *(Group #8367-17)*		
Vision		
• VSP *(IBEW only)*	800.877.7195	www.vsp.com
Flexible Spending Accounts *(Health Savings and Dependent Care FSAs)*		
• American Fidelity	800.662.1113	www.americanfidelity.com
Employee Assistance Plan (EAP)		
• Claremont Services	800.834.3773	www.claremonteap.com/
Deferred Compensation Plan *(optional plans)*		
• Mass Mutual 457 *(Plan #60035)*	Dennis Duarte: 800.835.8447	www.massmutual.com/serve
• CalPERS 457 *(Plan #450294)*	Nancy Garrity: 888.713.8244, x2	www.calpers.ca.gov
• Prudential 457 *(Plan 300287)*	Bruce Stuart: 415.693.6016	www.prudential.com
Retirement		
• CalPERS	888.225.7377	www.calpers.ca.gov
• SRIP - Mass Mutual	800.528.9009	
– SRIP I *(Plan #105751)*		
– SRIP II & III *(Plan #005751)*		
• SRIP - Prudential *(option at Open Enrollment)*	877.778.2100	
– SRIP I *(Plan #330287)*		
– SRIP II *(Plan #340287)*		
– SRIP III: Sworn Police *(Plan #360287)*		
• PARS	800.540.6369	
• Prudential Call Center *(automated transactions)*	877.778.2100	
Life Insurance/AD&D, LTD		
• Hartford	800.423.6789	www.thehartfordatwork.com

Glossary of Health Terms

Brand-Name Drug. FDA-approved prescription drugs marketed under a specific brand name by the manufacturer.

COBRA. This federal law allows employees and dependents who are enrolled in an employer-sponsored plan to temporarily continue receiving health coverage after certain qualifying events like termination or divorce.

Coinsurance. Coinsurance refers to the amount of money that a member is required to pay for healthcare services, after any required deductible has been paid. Coinsurance is specified by a percentage. For example, the employee pays 15% toward the charges for a covered service and the insurance company pays 85%.

Copay. The flat fee you pay each time you utilize a healthcare service or fill a prescription.

Deductible. The specified amount you must pay for healthcare in a plan year before the plan will begin to cover all or a portion of your costs. Some plans have no deductible.

Dependent. A family member or other individual who meets the eligibility criteria established by the City for enrollment in an available healthcare plan.

Effective Date. The actual date your healthcare coverage is scheduled to begin. You are not covered until the effective date.

Employee Premium Contribution. The amount you must pay toward the cost of your health plan premiums.

Employer Premium Contribution. The amount your employer pays toward the cost of your health plan premiums.

Employer-subsidized Benefits. Benefits that are paid for, all or in part, with money contributed by the employer.

Enrollee. Individual enrolled in a health plan.

Explanation of Benefits (EOB). Written, formal statement sent to PPO enrollees that lists the services provided, amounts paid and costs billed by the health plan.

Evidence of Coverage (EOC). The Evidence of Coverage is a legal document that gives details about plan benefits and exclusions and how to get the care you need. It explains your rights, benefits and responsibilities as a member of your plan and the plan providers' responsibilities to you.

Exclusions. The list of conditions, injuries, or treatments that are not covered under your health insurance policy. Exclusions can be found in your plan document called the Evidence of Coverage.

Flexible Spending Account (FSA). An account that you contribute to pre-tax and that reimburses you for qualified healthcare and dependent care expenses.

Formulary. A comprehensive list of prescription drugs that are covered by a medical plan. The formulary is designed to assist physicians in prescribing drugs that are medically necessary and cost-effective for members. The formulary is updated periodically.

Generic Drug. FDA-approved prescription drugs that are a therapeutic equivalent to the brand-name drug, contain the same active ingredient as the brand-name drug, and cost less that the brand-name drug equivalent.

Health Maintenance Organization (HMO). An entity that provides health services through a closed network. Unlike PPOs, HMOs either employ their own staff or contract with groups of providers. HMO participants typically need pre-approval from a primary care provider before seeing a specialist.

Imputed Income. Federal IRS regulations require that the value of non-cash compensation, such as an employer's contribution to the health insurance of an employee's domestic partner, be reported as taxable income on federal returns.

In-Network. These providers or facilities are contracted with a health plan to provide services at pre-negotiated fees. Enrollees usually pay less when using an in-network provider, because these networks provide services at lower cost to the insurance companies with which they have contracts.

Medical Group. An independent group of physicians and other healthcare providers that contract to provide services to members of an HMO.

Lifetime Maximum Benefit. The maximum amount a health plan will pay in benefits to an insured individual during that individual's lifetime.

Member. An employee or retiree designated as the primary plan subscriber, per the City rules.

Glossary of Health Terms (continued)

Non-Formulary Drug. A drug that is not on the insurer's list of approved medications. Non-formulary drugs can usually only be prescribed with a physician's special authorization.

Open Enrollment. The period of time when you can change your health benefit elections without a qualifying event.

Out-of-Area. A location outside the geographic area covered by a health plan's network of providers.

Out-of-Network. Providers or healthcare facilities which are not in your health plan's provider network. Some plans do not cover Out-of-network service costs. Others charge a higher copay for this type of service.

Out-of-Pocket Costs. The actual costs you pay, including premiums, copays and deductibles for your healthcare.

Out-of-Pocket Maximum. The amount of money that an individual must pay out of their own pocket, before an insurance company will pay 100% for an individual's healthcare expenses.

Point of Service (POS). Point of service insurance is one of three types of managed healthcare plans available in the United States. This type of healthcare plan combines features from the other two plans, the HMO (Health Maintenance Organization) and PPO (Preferred Provider Organization).

Preferred Provider Organization (PPO). An entity that contracts to provide healthcare services to subscribers at negotiated, often discounted, rates.

Premium. The amount charged by an insurer for healthcare coverage. This cost is usually shared by employer and employee.

Primary Care Physician (PCP). The doctor (or nurse practitioner) who coordinates all your medical care and treatment. HMOs require all plan participants be assigned to a PCP.

Qualifying Event. A change in your life situation that allows you to make a change in your benefit elections outside Open Enrollment. This includes marriage, domestic partnership, separation, divorce or dissolution of partnership, the birth or adoption of a child and the death of a dependent as well as obtaining or losing other healthcare coverage.

Reasonable and Customary Charges. The average fee charged by a particular type of healthcare practitioner within a geographic area. Often used by medical plans as the amount of money they will pay for a specific test or procedure. If the fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference.