



2016 Employee Benefits Overview





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Welcome to the City of San Leandro

The City of San Leandro takes pride in offering a benefits program that provides flexibility for the diverse and changing needs of our employees. We are pleased to provide you with the 2016 Employee Benefits Overview for eligible employees of the City of San Leandro. Please review this guide carefully and retain this guide for the calendar year 2016 as an easy reference to your benefit plan offerings.

The City of San Leandro offers you and your eligible dependents the following benefits:

- Medical and Dental Insurance
- Voluntary Vision Insurance
- Basic Life / Accidental Death & Dismemberment (AD&D) Insurance
- Long-Term Disability (LTD) Insurance
- Voluntary Short-Term Disability (STD) Insurance
- Flexible Spending Accounts (Medical and Dependent Care)
- Transportation Spending Account
- Employee Assistance Program (EAP)
- Deferred Compensation Plan
- Voluntary Pet Insurance

Summary

The information in this booklet is a general outline of the benefits offered under the City of San Leandro benefits program. Specific details and plan limitations are provided in the Summary Plan Description (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

If you have any questions or need additional information, please contact Human Resources at (510) 577-3396 or lbockhaus@sanleandro.org

Online Resource: <http://HumanResources/Benefits>



Open Enrollment

This booklet will give you information about the benefits which are available to you. Please read the information carefully. To help you make important decisions about your benefits, Human Resources is available to answer any questions you may have.

Open Enrollment

Beginning on September 14, 2015 and lasting through October 9, 2015, all plan participants will be eligible to participate in the annual open enrollment period. During Open Enrollment, you have the right to change group medical plans and add/or drop dependent coverage.

Your new plan benefits will be effective January 1, 2016 and will run through December 31, 2016. In order to ensure a smooth implementation, **your forms are due no later than October 9, 2015!**

Please Note: This year's open enrollment will be completed ONLINE through the Employee Services website. Most changes will be submitted through <https://eh-webext.sanleandro.org/edenweb/>.

Please call Human Resources if you have any questions.

Helpful Hints

Read through this guide to familiarize yourself with what decisions you have to make. Think about your current benefit plans. Are they still working for you? Have you experienced any changes or do you anticipate any that might make a different plan more suitable?

Gather additional information. Use the websites and phone numbers on page 29 to see which doctors and other healthcare providers you can use under the different plan choices. If you have dependents on your plan that live out of state, check on provisions for coverage of members away from home.



Eligibility for Benefits

Who Is Eligible

If you are a regular full-time employee working 40 hours or more per week, you may enroll in the benefits program on the first day of the month following your date of hire.

Dependent Eligibility

Your dependents are eligible for coverage under your health and welfare benefits package as long as they meet the requirements specified for each plan. Eligible dependents include:

- Your current spouse or state-registered domestic partner.
 - Definition of domestic partner pursuant to Family Code Section 297-297.5:
A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State, and at the time of filing, all of the following requirements are met:
 1. Both persons have a common residence.
 2. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
 - Both persons are members of the same sex.
 - One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C section 402 (a) for old-age insurance benefits or Title XVI Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over the age of 62.
 3. Both persons are capable of consenting to the domestic partnership.
 - “Have a common residence” means that both domestic partners share the same residence.
- Your natural children, stepchildren, domestic partner’s children, adopted children of which the employee is the legal guardian. In addition, such children must be:
 1. under age 26 (medical, dental and vision coverage only)
 2. under age 19, or age 23 if a full-time student (Life Insurance)
- Your disabled children age 26 (medical, dental and vision coverage) or 19/23 (Life Insurance) or older. Such disabled children must meet the same conditions as listed above and, in addition, are physically or mentally disabled on the date coverage would otherwise end because of age and continue to be disabled. For medical coverage only, the enrollment of a disabled dependent child over the age of 26 is subject to CalPERS approval.
- A child for whom you are required to provide benefits by a court order and who satisfies the same conditions as listed above.

This is a brief description of the eligibility requirements and is not intended to modify or supersede the requirements of the plan documents. The plan documents will govern in the event of any conflict between this description and the plan documents.



Dependent Eligibility Verification

All employees adding/removing dependents must submit documentation to verify their dependent's eligibility and/or Qualifying Life Event. The following chart is an easy guide to what documents must be submitted along with the Health Enrollment/Change form.

	Enrollment Form Required for CalPERS Only	Marriage Certificate Required	State of California Domestic Partner (DP) Registration	Birth Certificate/ Certificate of Adoption Required
Employee only	•			
Employee & Spouse	•	•		
Employee & Domestic Partner (DP)	•		•	
Employee & Children	•			•
Employee, Spouse/DP & Children	•	•	•	•

You are responsible for ensuring that the health enrollment information about you and your family members is accurate, and for reporting any changes in a timely manner. If you fail to maintain current and accurate health enrollment information, you may be liable for the reimbursement of health premiums or health care services incurred during the entire ineligibility period.

For example, if your divorce or dissolution occurred in 2005, yet you did not report it until 2009, your former spouse or domestic partner will be retroactively canceled from coverage effective the first of the month following the divorce or dissolution.

On page 6, you will find a detailed list of Qualifying Life Events, which must be reported to the Human Resources Department so we can make the appropriate change to your health coverage. All Qualifying Life Event changes must be made within 30 days (60 days for CalPERS medical plans) from the date of the event. Proper documentation is required, such as a copy of the marriage/domestic partnership certificate, birth/adoption certificate, or divorce/dissolution of domestic partnership decree.

For further clarification, please contact Human Resources at (510) 577-3396.



When You Can Make Changes

Other than during the annual Open Enrollment period, you may not change your coverage unless you experience a qualifying life event.

Qualifying life events include:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, dissolution of domestic partnership, and death of a spouse.
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child.
- Change in employment status, including the start or termination of employment by you, your spouse, or your dependent child.
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits.
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment.
- Change in an individual's eligibility for Medicare or Medicaid.
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child or dependent foster child.
- An event that is a qualifying life event under the Health Insurance Portability and Accountability Act (HIPAA), including acquisition of a new dependent or spouse or loss of coverage under another health insurance policy or plan if the coverage is terminated because of:
 - Voluntary or involuntary termination of employment or reduction in hours of employment or death, divorce, or legal separation;
 - Termination of employer contributions toward the other coverage, OR if the other coverage was COBRA Continuation Coverage, exhaustion of the coverage.

Important—Two rules apply to making changes to your benefits during the year:

- Any changes you make must be consistent with the change in status, AND
- You must make the changes within 30 days (60 days for CalPERS medical plans) of the date the event (marriage, birth, etc.) occurs.

If you must make mid-year changes to your insurance (adding/dropping dependents), contact Human Resources and provide supporting documents within 30 days of the change in status.



Medical Benefits

The goal of the City of San Leandro is to provide you with affordable, quality health care benefits. Our medical benefits are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. The City offers a choice of medical plans through the CalPERS Medical Program.

Anthem Blue Cross, Blue Shield, Kaiser Permanente, Health Net SmartCare, and UnitedHealthcare

Health Maintenance Organization (HMO)

Under the HMO plans, most services and medicines are covered with a small copayment. You select a Primary Care Physician (PCP) to coordinate your care. You have a choice between the CalPERS Anthem Blue Cross Select, Anthem Blue Cross Traditional, Blue Shield Access+, Blue Shield Net Value, Kaiser Permanente and UnitedHealthcare Alliance HMO plans.*

*Not all HMO plans are available in all California counties. To see if these plans are available in your zip code, please visit the CalPERS website at www.calpers.ca.gov and use the zip code finder search engine.

Anthem Blue Cross

Preferred Provider Organization (PPO)

The Anthem Blue Cross PPO plan is designed to provide choice, flexibility and value. The PPO plan is a managed care organization of medical doctors, hospitals, and other health care providers who have contracted with the Anthem Blue Cross to provide health care at reduced rates to you. Participants have a choice of using network providers or going directly to any other physician (non-network provider) without a referral. There is an annual deductible to meet before benefits apply. You are also responsible for a certain percentage of the charges (coinsurance), and the plan pays the balance up to the agreed upon amount. You have a choice between the CalPERS Anthem Blue Cross PERS Choice, PERS Select, PERSCare, and PORAC plans.

Forms must be returned to Human Resources by October 9, 2015 to ensure enrollment and for coverage to be effective January 1, 2016.

Why Would I Choose the PPO Plan?	Why Would I Not Choose the PPO Plan?
<ul style="list-style-type: none"> You have a doctor you like and you would like to keep this doctor. You want to see specialists and other providers without having to first get a referral and/or pre-approval. You want the freedom to see providers who are not in the network. You are confident that you can manage your own care. You do not want a primary care doctor. 	<ul style="list-style-type: none"> You don't want the extra responsibility of managing your own care. PPOs are not as closely regulated by the government as HMOs. You do not want to pay the higher costs of a PPO. You do not want to get bills from providers.



Medical Plan Options—Anthem Blue Cross Medical Plan

Medical Benefits	Anthem Blue Cross Traditional and Select HMO
Calendar Year Deductible	N/A
Annual Out-of-Pocket Maximum ¹ (Excluding Pharmacy)	\$1,500 individual / \$3,000 family
Physician Office Visit	\$15 / visit
Preventive Care	No charge
Lab and X-Ray	No charge
Hospitalization Inpatient	No charge
Outpatient	No charge
Emergency Room Services & Supplies	\$50 / visit (waived if admitted)
Chiropractic and Acupuncture (20 visits per calendar year combined benefit)	\$15 / visit
Home Health	No charge
Mental Health/Substance Abuse Inpatient	No charge
Outpatient	\$15 copay
Prescription Rx: Retail (Up to 30 day supply)	
Generic Rx	\$5 copay
Brand Name Rx	\$20 copay
Non-Formulary Rx	\$50 copay
Prescription Rx: Mail Order (Up to 90 day supply)	
Generic Rx	\$10 copay
Brand Name Rx	\$40 copay
Non-Formulary	\$100 copay

¹For 2016, the Affordable Care Act (ACA) limits maximum out-of-pocket (MOOP) amounts for health plans to \$6,850/\$13,700 for individuals/families, for both medical and pharmacy benefits combined.



Medical Plan Options—Blue Shield Medical Plan

Medical Benefits	Blue Shield Access+ and Net Value HMO
Calendar Year Deductible	N/A
Annual Out-of-Pocket Maximum ¹ (Excluding Pharmacy)	\$1,500 individual / \$3,000 family
Physician Office Visit	\$15 / visit
Preventive Care	No charge
Lab and X-Ray	No charge
Hospitalization Inpatient	No charge
Outpatient	No charge
Emergency Room Services & Supplies	\$50 / visit (waived if admitted)
Chiropractic and Acupuncture (20 visits per calendar year combined benefit)	\$15 / visit
Home Health	No charge
Mental Health/Substance Abuse Inpatient	No charge
Outpatient	\$15 copay
Prescription Rx: Retail (Up to 30 day supply)	
Generic Rx	\$5 copay
Brand Name Rx	\$20 copay
Non-Formulary Rx	\$50 copay
Prescription Rx: Mail Order (Up to 90 day supply)	
Generic Rx	\$10 copay
Brand Name Rx	\$40 copay
Non-Formulary	\$100 copay

You must choose a Primary Care Physician (PCP) from the Blue Shield Network. If one is not selected at the time of enrollment, Blue Shield will assign a PCP and a letter of explanation will be sent to you. You may change your PCP, subject to availability, by contacting Blue Shield Customer Service at (800) 334-5847 or accessing the Blue Shield website at www.blueshieldca.com/calpers.

¹For 2016, the Affordable Care Act (ACA) limits maximum out-of-pocket (MOOP) amounts for health plans to \$6,850/\$13,700 for individuals/families, for both medical and pharmacy benefits combined.



Medical Plan Options—Kaiser Permanente Medical Plan

Medical Benefits	Kaiser Permanente HMO
Calendar Year Deductible	N/A
Annual Out-of-Pocket Maximum ¹ (Excluding Pharmacy)	\$1,500 individual / \$3,000 family
Physician Office Visit	\$15 / visit
Preventive Care	No charge
Lab and X-Ray	No charge (some procedures may require a copay)
Hospitalization Inpatient	No charge
Outpatient	\$15 copay
Emergency Room Services & Supplies	\$50 / visit (waived if admitted)
Chiropractic and Acupuncture (20 visits per calendar year combined benefit)	\$15 / visit
Home Health	No charge (pre-authorization required)
Mental Health/Substance Abuse Inpatient	No charge
Outpatient	\$15 copay individual / \$5 copay group
Prescription Rx: Retail (Up to 30 day supply) Generic Rx	\$5 copay
Brand Name Rx	\$20 copay
Prescription Rx: Mail Order (Up to 100 day supply) Generic Rx	\$10 copay
Brand Name Rx	\$40 copay

¹For 2016, the Affordable Care Act (ACA) limits maximum out-of-pocket (MOOP) amounts for health plans to \$6,850/\$13,700 for individuals/families, for both medical and pharmacy benefits combined.



Medical Plan Options—UnitedHealthcare Medical Plan

Medical Benefits	UnitedHealthCare Alliance HMO
Calendar Year Deductible	N/A
Annual Out-of-Pocket Maximum ¹ (Excluding Pharmacy)	\$1,500 individual / \$3,000 family
Physician Office Visit	\$15 / visit
Preventive Care	No charge
Lab and X-Ray	No charge
Hospitalization Inpatient	No charge
Outpatient	No charge
Emergency Room Services & Supplies	\$50 / visit (waived if admitted)
Chiropractic and Acupuncture (20 visits per calendar year combined benefit)	\$15 / visit
Home Health	No charge
Mental Health/Substance Abuse Inpatient	No charge
Outpatient	\$15 copay
Prescription Rx: Retail (Up to 30 day supply)	
Generic Rx	\$5 copay
Brand Name Rx	\$20 copay
Non-Formulary Rx	\$50 copay
Prescription Rx: Mail Order (Up to 90 day supply)	
Generic Rx	\$10 copay
Brand Name Rx	\$40 copay
Non-Formulary	\$100 copay

You must choose a Primary Care Physician (PCP) from the contracting/participating network.

¹For 2016, the Affordable Care Act (ACA) limits maximum out-of-pocket (MOOP) amounts for health plans to \$6,850/\$13,700 for individuals/families, for both medical and pharmacy benefits combined.



Medical Plan Options—Health Net SmartCare Medical Plan

Medical Benefits	Health Net SmartCare HMO
Calendar Year Deductible	N/A
Annual Out-of-Pocket Maximum ¹ (Excluding Pharmacy)	\$1,500 individual / \$3,000 family
Physician Office Visit	\$15 / visit
Preventive Care	No charge
Lab and X-Ray	No charge
Hospitalization Inpatient	No charge
Outpatient	No charge
Emergency Room Services & Supplies	\$50 / visit (waived if admitted)
Chiropractic and Acupuncture (20 visits per calendar year combined benefit)	\$15 / visit
Home Health	No charge
Mental Health/Substance Abuse Inpatient	No charge
Outpatient	\$15 copay
Prescription Rx: Retail (Up to 30 day supply)	
Generic Rx	\$5 copay
Brand Name Rx	\$20 copay
Non-Formulary Rx	\$50 copay
Prescription Rx: Mail Order (Up to 90 day supply)	
Generic Rx	\$10 copay
Brand Name Rx	\$40 copay
Non-Formulary	\$100 copay

You must choose a Primary Care Physician (PCP) from the contracting/participating network.

¹For 2016, the Affordable Care Act (ACA) limits maximum out-of-pocket (MOOP) amounts for health plans to \$6,850/\$13,700 for individuals/families, for both medical and pharmacy benefits combined.



Medical Plan Options—Anthem Blue Cross Medical Plan

Medical Benefits	PERS Select PPO		
	Network	Non-Network*	
Calendar Year Deductible	\$500 Individual / \$1,000 Family		
Annual Out-of-Pocket Maximum ¹ (Excluding Pharmacy)	\$3,000 Individual / \$6,000 Family	None	
Physician Office Visit	\$20 / Visit (deductible waived)	40%	
Preventive Care	No Charge (deductible waived)	40%	
Lab and X-Ray	20% of Negotiated Fee	40%	
Hospitalization Inpatient / Outpatient	20%-30% of Negotiated Fee	40%	
Emergency Room Services & Supplies	\$50 copay, then 20% of Negotiated Fee (copay waived if admitted)		
Chiropractic and Acupuncture (15 visits per calendar year combined benefit)	20% of Negotiated Fee	40%	
Home Health (Up to \$6,000 per calendar year)	20% of Negotiated Fee	40%	
Mental Health/Substance Abuse Inpatient/Outpatient	20%-30% of Negotiated Fee	40%	
Prescription Rx: Retail (Up to 30 day supply)	Generic Rx	\$5 copay	\$5 copay**
	Brand Name Rx	\$20 copay	\$20 copay**
	Non-Formulary Rx	\$50 copay	\$50 copay**
Prescription Rx: Mail Order (Up to 90 day supply)	Generic Rx	\$10 copay	\$10 copay**
	Brand Name Rx	\$40 copay	\$40 copay**
	Non-Formulary	\$100 copay	\$100 copay**

*Non-network benefits based upon Anthem Blue Cross' Reasonable and Customary (R&C) charges.

**When filling prescriptions at non-participating pharmacies, you are required to pay the listed dollar copayment (if applicable), plus 50% of the prescription drug's Maximum Allowed Amount (MAA). You are also obligated to pay any amounts the pharmacy charges in excess of the MAA.

¹For 2016, the Affordable Care Act (ACA) limits maximum out-of-pocket (MOOP) amounts for health plans to \$6,850/\$13,700 for individuals/families, for both medical and pharmacy benefits combined.



Medical Plan Options—Anthem Blue Cross Medical Plan

Medical Benefits	PERS Choice PPO		
	Network	Non-Network*	
Calendar Year Deductible	\$500 Individual / \$1,000 Family		
Annual Out-of-Pocket Maximum ¹ (Excluding Pharmacy)	\$3,000 Individual / \$6,000 Family	None	
Physician Office Visit	\$20 / Visit (deductible waived)	40%	
Preventive Care	No Charge (deductible waived)	40%	
Lab and X-Ray	20% of Negotiated Fee	40%	
Hospitalization Inpatient/Outpatient	20%-30% of Negotiated Fee	40%	
Emergency Room Services & Supplies	\$50 copay, then 20% of Negotiated Fee (copay waived if admitted)		
Chiropractic and Acupuncture (15 visits per calendar year combined benefit)	20% of Negotiated Fee	40%	
Home Health (Up to \$6,000 per calendar year)	20% of Negotiated Fee	40%	
Mental Health/Substance Abuse Inpatient/Outpatient	20%-30% of Negotiated Fee	40%	
Prescription Rx: Retail (Up to 30 day supply)	Generic Rx	\$5 copay	\$5 copay**
	Brand Name Rx	\$20 copay	\$20 copay**
	Non-Formulary Rx	\$50 copay	\$50 copay**
Prescription Rx: Mail Order (Up to 90 day supply)	Generic Rx	\$10 copay	\$10 copay**
	Brand Name Rx	\$40 copay	\$40 copay**
	Non-Formulary	\$100 copay	\$100 copay**

*Non-network benefits based upon Anthem Blue Cross' Reasonable and Customary (R&C) charges.

**When filling prescriptions at non-participating pharmacies, you are required to pay the listed dollar copayment (if applicable), plus 50% of the prescription drug's Maximum Allowed Amount (MAA). You are also obligated to pay any amounts the pharmacy charges in excess of the MAA.

¹For 2016, the Affordable Care Act (ACA) limits maximum out-of-pocket (MOOP) amounts for health plans to \$6,850/\$13,700 for individuals/families, for both medical and pharmacy benefits combined.



Medical Plan Options—Anthem Blue Cross Medical Plan

Medical Benefits	PERSCare PPO	
	Network	Non-Network*
Calendar Year Deductible	\$500 Individual / \$1,000 Family	
Annual Out-of-Pocket Maximum ¹ (Excluding Pharmacy)	\$2,000 Individual / \$4,000 Family	None
Physician Office Visit	\$20 / Visit (deductible waived)	40%
Preventive Care	No Charge (deductible waived)	40%
Lab and X-Ray	10% of Negotiated Fee	40%
Hospitalization	Inpatient	\$250 per admit deductible, then 10%
	Outpatient	10% of Negotiated Fee
Emergency Room Services & Supplies	\$50 copay, then 10% of Negotiated Fee (copay waived if admitted)	
Chiropractic and Acupuncture (15 visits per calendar year combined benefit)	10% of Negotiated Fee	40%
Home Health (Up to 100 visits per calendar year)	10% of Negotiated Fee	40%
Mental Health/Substance Abuse Inpatient/Outpatient	\$250 per admit deductible, then 10%	\$250 per admit deductible, then 40%
	10% of Negotiated Fee	40%
Prescription Rx: Retail (Up to 30 day supply)	Generic Rx	\$5 copay
	Brand Name Rx	\$20 copay
	Non-Formulary Rx	\$50 copay
Prescription Rx: Mail Order (Up to 90 day supply)	Generic Rx	\$10 copay
	Brand Name Rx	\$40 copay
	Non-Formulary	\$100 copay

*Non-network benefits based upon Anthem Blue Cross' Reasonable and Customary (R&C) charges. **When filling prescriptions at non-participating pharmacies, you are required to pay the listed dollar copayment (if applicable), plus 50% of the prescription drug's Maximum Allowed Amount (MAA). You are also obligated to pay any amounts the pharmacy charges in excess of the MAA.

¹For 2016, the Affordable Care Act (ACA) limits maximum out-of-pocket (MOOP) amounts for health plans to \$6,850/\$13,700 for individuals/families, for both medical and pharmacy benefits combined.



Medical Plan Options—Anthem Blue Cross Medical Plan

Medical Benefits	PORAC	
	Network	Non-Network*
Calendar Year Deductible	\$300 Individual / \$900 Family	\$600 Individual / \$1,800 Family
Annual Out-of-Pocket Maximum ¹ (Excluding Pharmacy)	\$3,300 Individual / \$6,600 Family	
Physician Office Visit	\$20 / Visit (deductible waived)	10%
Preventive Care (\$500 combined maximum per calendar year)	No Charge (deductible waived)	No Charge (deductible waived)
Lab and X-Ray	10% of Negotiated Fee	10%
Hospitalization Inpatient/Outpatient	10% of Negotiated Fee	10%
Emergency Room Services & Supplies	10% of Negotiated Fee	
Chiropractic and Acupuncture	\$20 copay, then 10% of Negotiated Fee	10% (max \$35/visit and \$700 per calendar year combined)
Home Health (Up to 100 visits per calendar year)	10% of Negotiated Fee	10%
Mental Health/Substance Abuse Inpatient/Outpatient	10% of Negotiated Fee	10%
Prescription Rx: Retail (Up to 30 day supply)		
Generic Rx	\$10 copay	\$10 copay**
Brand Name Rx	\$25 copay	\$25 copay**
Non-Formulary Rx	\$45 copay	\$45 copay**
Prescription Rx: Mail Order (Up to 90 day supply)		
Generic Rx	\$20 copay	n/a
Brand Name Rx	\$40 copay	n/a
Non-Formulary	\$75 copay	n/a

*Non-network benefits based upon Anthem Blue Cross' Reasonable and Customary (R&C) charges.

**When filling prescriptions at non-participating pharmacies, you are required to pay the listed dollar copayment (if applicable), plus 50% of the prescription drug's Maximum Allowed Amount (MAA). You are also obligated to pay any amounts the pharmacy charges in excess of the MAA.

¹For 2016, the Affordable Care Act (ACA) limits maximum out-of-pocket (MOOP) amounts for health plans to \$6,850/\$13,700 for individuals/families, for both medical and pharmacy benefits combined.



Dental Benefits (Administered by Delta Dental)

Under the Delta Dental Preferred Provider Organization (PPO) plan, dental services are provided through the Delta Dental PPO network. However, you can choose to visit any dentist in any location inside or outside of the Delta Dental network. How much you pay for dental services depends on whether you choose a participating Delta Dental dentist. If you choose a non-participating dentist, you pay the difference between the amount the dentist receives from Delta Dental (the “allowable amount”) and the dentist’s charges.

You may also choose to visit a Delta Dental Premier provider. Premier dentists may not balance bill above Delta Dental’s allowable amount, so your out-of-pocket costs may be lower than with a non-participating dentist. Your costs are usually lowest when you visit a Delta Dental PPO dentist. Pre-authorization from Delta Dental is recommended for charges of \$250 or more.

Core Plan		
Dental Benefits	Delta Dental PPO	Premier and Non-Delta*
Calendar Year Maximum	\$2,000	
Calendar Year Deductible Individual / Family	\$0	\$25 / \$75
Diagnostic and Preventive Oral Examinations X-Rays Teeth Cleaning Fluoride Treatment Space Maintainers Bitewings Sealants	100% (deductible waived)	85% (deductible waived)
Basic Services Amalgam/Composite Filings Periodontics (Gum disease) Endodontics (Root Canal) Extractions & Other Simple Oral Surgery	90%	75%
Major Services Crown Repair Restorative - Inlays and Crowns Prosthodontics	55%	55%
Orthodontia Adults and Children up to age 26 (Lifetime max \$500)	50%	50%

* Non-Delta Dentists are reimbursed at the lesser of the submitted charge or the fee that satisfies the majority of dentists in the same geographical area with the same training (51st percentile of Usual, Customary and Reasonable)

Limitations may apply for some benefits; some services may be excluded. Please refer to your Evidence of Coverage or Summary Plan Description for waiting periods and a list of benefit limitations and exclusions.



Dental Benefits (Administered by Delta Dental)

Under the Delta Dental Preferred Provider Organization (PPO) plan, dental services are provided through the Delta Dental PPO network. However, you can choose to visit any dentist in any location inside or outside of the Delta Dental network. How much you pay for dental services depends on whether you choose a participating Delta Dental dentist. If you choose a non-participating dentist, you pay the difference between the amount the dentist receives from Delta Dental (the “allowable amount”) and the dentist’s charges.

You may also choose to visit a Delta Dental Premier provider. Premier dentists may not balance bill above Delta Dental’s allowable amount, so your out-of-pocket costs may be lower than with a non-participating dentist. Your costs are usually lowest when you visit a Delta Dental PPO dentist. Pre-authorization from Delta Dental is recommended for charges of \$250 or more.

Buy-Up Plans				
Dental Benefits	Option 1 Delta Dental PPO	Option 1 Premier and Non-Delta*	Option 2 Delta Dental PPO	Option 2 Premier and Non-Delta*
Calendar Year Maximum	\$2,500	\$2,000	\$2,000	
Calendar Year Deductible Individual / Family	\$0		\$0	
Diagnostic and Preventive Oral Examinations X-Rays Teeth Cleaning Fluoride Treatment Space Maintainers Bitewings Sealants	100% (deductible waived)		100% (deductible waived)	
Basic Services Amalgam/Composite Filings Periodontics (Gum disease) Endodontics (Root Canal) Extractions & Other Simple Oral Surgery	90%	85%	90%	85%
Major Services Crown Repair Restorative - Inlays and Crowns Prosthodontics	65%	60%	65%	60%
Orthodontia Adults and Children up to age 26	50% (lifetime max \$1,500)		50% (lifetime max \$3,000)	

* Non-Delta Dentists are reimbursed at the lesser of the submitted charge or the fee that satisfies the majority of dentists in the same geographical area with the same training (51st percentile of Usual, Customary and Reasonable)

Limitations may apply for some benefits; some services may be excluded. Please refer to your Evidence of Coverage or Summary Plan Description for waiting periods and a list of benefit limitations and exclusions.



Vision Benefits (Administered by EyeMed)

You are eligible for vision coverage through EyeMed Vision. EyeMed provides coverage for eye exams and materials, such as lenses and frames.

Plan Benefits	Low Plan (network)	Low Plan (non-network)	High Plan (network)	High Plan (non-network)
Exam	\$10 copay	Plan pays up to \$35	\$10 copay	Plan pays up to \$35
Materials Copay*	\$25		\$10	
Single Lenses	Covered in Full	Plan pays up to \$35	Covered in Full	Plan pays up to \$35
Bifocal Lenses**	Covered in Full	Plan pays up to \$49	Covered in Full	Plan pays up to \$49
Trifocal Lenses**	Covered in Full	Plan pays up to \$74	Covered in Full	Plan pays up to \$74
Contact Lenses Fitting and Evaluation	Up to \$40	N/A	Up to \$40	N/A
Contact Lenses*** Elective	Up to \$135	Plan pays up to \$108	Up to \$155	Plan pays up to \$124
Medically Necessary	Covered in Full	Plan pays up to \$200	Covered in Full	Plan pays up to \$200
Frames	\$120 Allowance	Plan pays up to \$60	\$140 Allowance	Plan pays up to \$70
Benefit Frequency Exam Lenses and Contacts*** Frames	Every 12 Months Every 12 Months Every 24 Months		Every 12 Months Every 12 Months Every 12 Months	

*Materials copay: When purchasing eyewear, a \$25 or \$10 copay will be required, depending on the plan you select.

**No-lined lenses are not a covered benefit under this plan. When requested, the lenses will be covered up to the value of the lined lenses and you will pay the additional cost.

***When you choose contacts instead of glasses, your \$120 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts.



Life and Disability Benefits (Administered by Sun Life Financial)

Basic Life and AD&D Insurance

Basic Life insurance provides income protection for your beneficiary in the event of your death. The City of San Leandro currently provides Basic Life/AD&D insurance coverage at one times your annual base salary, up to a maximum amount, which varies by class, at no cost to you. The chart below outlines general benefits provided under the plan. Please refer to your life insurance certificate of coverage for more details.

Basic Life/AD&D	
Benefit	Management Employees: \$50,000 Non-Management Employees: \$20,000

Supplemental Life and Accidental Death & Dismemberment (AD&D) Insurance

Supplemental Life/AD&D Insurance allows you to purchase additional life insurance coverage, as well as coverage for your spouse/domestic partner and/or child(ren). Coverage purchased for your spouse/domestic partner or child(ren) will pay a benefit to you if your spouse/domestic partner or child should die.

Supplemental Life/AD&D*			
Benefits	Employee	Spouse/Domestic Partner	Child(ren)
Benefit	\$20,000 increments up to \$400,000 (not to exceed 5x annual salary)	\$10,000 increments up to \$250,000 (not to exceed 50% of employee benefit)	\$250 (14 days - 6 months) \$5,000 or \$10,000 (6 months - 19, 25 if FTS)
Minimum Benefit	\$20,000	\$10,000	n/a
Guarantee Issue	Under age 60: \$100,000 60-69: \$40,000 Over age 70: \$20,000	Under age 60: \$30,000 60-69: \$10,000	n/a

*You may elect AD&D for yourself and your spouse/DP in the amount equal to your elected insurance. AD&D rates are \$0.05 per \$1,000 units purchased. See page 20 for Supplemental Life rates.

Please remember to update your beneficiary information whenever there is a family status change.



Life and Disability Benefits (Administered by Sun Life Financial)

Supplemental Life Insurance Rate Calculation—Active Employee and Spouse/DP Rates

You may elect up to **\$500,000** of Supplemental Life Insurance for yourself, in increments of \$10,000. You are guaranteed coverage for \$100,000 if under age 60, \$40,000 if ages 60 to 69, and \$20,000 if age 70 and older. Any amount you elect above the guarantee issue amount will be subject to medical underwriting.

You may elect up to **\$250,000** of Supplemental Life Insurance for your spouse/domestic partner, in increments of \$10,000, not to exceed 50% of your election. Your spouse/domestic partner is guaranteed coverage for \$30,000 if under age 60 and \$10,000 if ages 60 to 69.

You may elect Supplemental AD&D coverage for yourself and/or your spouse/DP that is equal to the amount of Supplemental Life purchased. Supplemental AD&D rates are \$0.05 per \$1,000.

If you elect Supplemental Life/AD&D insurance for yourself, and/or your spouse/domestic partner, your monthly premium rate for this coverage is indicated in the table below. Premiums for this coverage will be deducted directly from your paycheck.

Age	Rate (per \$10,000 Unit)
Under Age 29	\$0.66
30-34	\$0.79
35-39	\$1.07
40-44	\$1.20
45-49	\$1.52
50-54	\$2.30
55-59	\$3.52
60-64	\$6.58
65-69	\$10.10
70+	\$31.51

To calculate the monthly premium:

1. Amount Elected: Write the amount of units you want. (1 unit = \$10,000) Line 1: _____
2. Write your age-based rate from the table to the left. Line 2: _____
3. Multiple Line 1 by Line 2. This is your monthly premium amount. Line 3: _____

Example:

*40 year old employee requesting \$250,000 =
25 x \$1.20 = \$30.00/monthly premium*

Supplemental Life Insurance Rate Calculation—Dependent Child(ren) Rates

You may elect up to **\$10,000** of Supplemental Life Insurance for your child(ren) at a rate of \$0.178 per \$1,000 benefit.

Age	Benefit
0 to 14 days	None
15 days to 6 months	\$250
6 months to 19 years (25 if FTS)	\$5,000 or \$10,000

To calculate the monthly premium:

Example:

*16 year old daughter at \$10,000 =
10 x \$0.178 = \$1.78 monthly premium*

Please remember to update your beneficiary information whenever there is a family status change.



Life and Disability Benefits (Administered by Sun Life Financial)

Voluntary Short Term Disability (STD)

When an illness or injury make it impossible for you to work for an extended period of time, your income may be continued under the City of San Leandro's STD or LTD plan. Under the STD plan, if you are disabled for longer than two (2) weeks, you may become eligible for salary protection on a weekly basis.

SLCEA employees are automatically enrolled in STD.

Short Term Disability (STD)	
Eligibility	All Full-Time Active Employees (minimum 40 hours) POA not covered
Elimination Period - Sickness	14 days
Elimination Period - Accident	0 days
Weekly Benefit Percentage	60%
Maximum Weekly Benefit	\$3,000
Maximum Benefit Duration	26 weeks

*2016 STD Rates are not available as of 9/8/2015. Please check with your Human Resources Department.



Life and Disability Benefits (Administered by Sun Life Financial)

Long Term Disability (LTD)

Under the plan, if you are disabled for more than six (6) months, you could receive a percentage of your salary (up to a maximum dollar amount per month) until you are able to return to work. The City pays the entire cost of Core LTD coverage. Voluntary LTD coverage may be purchased to provide a higher percentage of salary replacement, up to the maximum of \$6,000 monthly benefit.

Long Term Disability (LTD)	
Eligibility	All Full-Time Active Employees (minimum 40 hours) POA not covered
Elimination Period	180 Days
Monthly Benefit Core Plan (City-Paid) Buy-Up Option 1: Buy-Up Option 2: Buy-Up Option 3:	40% of Monthly Earnings 50% of Monthly Earnings 60% of Monthly Earnings 66.67% of Monthly Earnings
Maximum Monthly Benefit	\$6,000
Minimum Monthly Benefit	\$100



Travel Assist (Administered by Sun Life Financial)

We are pleased to announce that, as an added feature to your employee benefits package, you have access to emergency medical assistance while you travel. This program is made available to you through Sun Life Assurance Company of Canada, and the services are provided by Assist America.

Assist America's travel assistance services include: medical consultation and evaluation, medical referrals, hospital admission guarantee, critical care monitoring, and if medically necessary, evacuation by whatever mode of transport necessary to the nearest facility that can appropriately treat your situation. Also, when you are ready to be discharged from a hospital and need medical assistance to return home (or to a rehabilitation facility).

Assist America will arrange your transportation and provide an escort, if necessary. In order to be eligible for services, you must be traveling no more than 90 consecutive days in a location that is:

- 100 miles or more from your place of residence, or
- A foreign country

If you haven't already received the Emergency Travel Assistance Services brochure containing your Assist America member ID card and lots of helpful information about the program, contact Human Resources.

Here are a few things to keep in mind:

- Always carry your Assist America member ID card whenever you travel.
- Assist America cannot reimburse participants for services that it did not provide.
- To access Assist America services, simply call a number on your member ID card:
- **Call toll free in the U.S. (800) 872-1414**
- **Call collect outside of the U.S. (301) 656-4152**
- Tell them your Sun Life Assurance Company of Canada reference number
- is **01-AA-SUL-100101**

BON VOYAGE!

www.assistAmerica.com

Reference Number: 01-AA-SUL-100101

This service will not replace your health insurance. In order to get reimbursed for medical bills, please follow the procedures outlined by your health insurance plan. The Assist America staff is available 24 hours a day, 365 days a year to help ensure that you obtain appropriate emergency travel assistance when you are 100 miles or more from home.



Employee Assistance Program (Administered by MHN)

The Employee Assistance Program (EAP) is designed to help with short-term counseling needs. It offers quick and easy access to confidential, professional assistance and resources to help you and your family address difficulties related to emotional concerns, relationships, substance abuse, legal and financial concerns.

If it is determined that more than **five** (5) sessions are needed for your specific situation, the EAP will help coordinate your needs under your medical plan.

All services are confidential and in accordance with professional ethics and Federal and state laws. Use of the EAP is strictly voluntary.

Work & Life Services

Depending on your plan, telephonic consultation may be available for:

- **Child and Eldercare Assistance** – Help accessing available community and financial resources and referrals to pre-screened providers for childcare, eldercare and more. You may also be entitled to help with adoption, parenting skills, child development, special needs, emergency care, relocation services and educational issues.
- **Financial Issues** – Budgeting, credit and financial guidance (tax or investment advice, loans and bill payments not included).
- **Federal Tax Assistance** – Help with IRS audits and unfiled or past-due tax returns (not a tax representation or preparation service).
- **Pre-Retirement Planning** – Guidance for planning a quality retirement (does not include investment, tax or legal advice).
- **Organizing Life's Affairs** – Help organizing records and vital documents and with arranging “final details” for a loved one.
- **Concierge Services** – Referrals for everyday errands, travel, event planning and more (does not cover the cost, nor guarantee delivery, of services).
- **Legal Services** – Telephonic or face-to-face legal consultations for issues relating to civil, consumer, personal and family law, financial matters, business law, real estate, criminal matters, the IRS and estate planning (excluding disputes or actions between members and their employer or MHN).

MHN EAP services are accessible 24-hours a day for all locations.
Toll-free (800) 242-6220 or online at members.mhn.com (Access Code: sanleandro)



FSA (Administered by Discovery Benefits)

The Flexible Spending Accounts (FSA) are a great way to use pre-tax dollars to pay for expenses paid with after-tax dollars! You may enroll in either or both the Healthcare Spending Account or the Dependent Care Spending Account. These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts. Money from these accounts is then used to pay eligible expenses that are not reimbursed by your health plans, as well as reimbursement for dependent care expenses.

Pre-tax means the dollars you allocate toward these accounts are not subject to social security tax, Federal income tax and, in most cases, state and local taxes. The money you set aside may be used for qualified eligible expenses on a pre-tax basis.

At enrollment, you determine the amount of money to contribute to one or both of these accounts for the City's plan year. The contributions are deducted pre-tax per pay period from your paycheck and deposited into the FSA account(s). You request reimbursement of qualified expenses as you incur the expenses from your FSA account(s).

Healthcare Spending Account

The maximum amount you may contribute to the Healthcare Spending Account for the Plan Year is **\$2,550**. This account will reimburse you with pre-tax dollars for qualified out-of-pocket healthcare expenses not covered under your family's healthcare plans. The "Use it or Lose it" rule applies if you do not incur expenses by December 31st of the plan year following your contributions, you lose the unexpended portion.

Medical-related expenses include out of pocket money for copays or deductibles for medical, dental and vision services. A detailed listing of all qualified expenses are available on the Discovery Benefits' website at www.discoverybenefits.com.

You can now carryover up to \$500 of unused Healthcare FSA funds at the end of the plan year. The amount you carryover is in addition to your regular annual election.

Note: FSA elections are not automatic. You must re-enroll during Open Enrollment to participate in the FSA for the 2016 plan year.

USE IT OR LOSE IT!

Please estimate your annual contributions carefully! If you don't use all the money in your account by December 31st, you lose the unexpended portion. However, you can now carryover up to \$500 of unused Healthcare FSA funds at the end of the plan year. Participants will have until March 31st of the following plan year to submit claims for expenses incurred during said plan year.



FSA (Administered by Discovery Benefits)

Dependent Care Spending Account

The maximum amount you may contribute to the Dependent Care Spending Account is **\$5,000** each calendar year, or **\$2,500** each calendar year if you are married but file separate tax returns. This account will reimburse you with pre-tax dollars for daycare expenses for your child(ren) and other qualifying dependents. These include expenses for child care or dependent adult care for a member of your household.

Eligible Dependents Include:

- Children under the age of 13 who qualify as dependents on your Federal tax return; and
- Children or other dependents of any age who are physically or mentally unable to care for themselves and who qualify as dependents on your Federal tax return. You may use the Federal childcare tax credit and the Dependent Care Spending Account; however, your Federal credit will be offset by any amount deferred into dependent care plan.

Note: FSA elections are not automatic. You must re-enroll during Open Enrollment to participate in the FSA for the 2016 plan year.

USE IT OR LOSE IT!

Please estimate your annual contributions carefully! If you don't use all the money in your account by December 31st, you lose the unexpended portion. Participants will have until March 31st of the following plan year to submit claims for expenses incurred during said plan year.



Transportation Spending Account (Administered by Discovery Benefits)

Discovery Benefits offers a Transportation Spending Account to save you money. With this program, you pay for your commuting costs with pre-tax dollars up to the monthly IRS limits. This means you don't pay federal income or social security taxes on this money, which lowers your taxable income.

Commuter Benefit

Pay for transportation to and from work tax free. Common eligible expenses include transportation through train, bus, subway, and ferry. **Up to \$130 per month** can be contributed on a pre-tax basis.

Parking Benefit

Who couldn't use little more money? The Parking Benefit is a great perk that saves you 40% or more! A Parking Benefits Plan is a great way to reduce your commuting expenses by allowing you to set aside pre-tax money for qualified parking expenses.

Pay for parking at or near your regular place of employment tax free. **Up to \$250 per month** can be contributed on pre-tax basis.

If the parking facility does not accept debit card payments, participants may also pay out of pocket and then submit a claim online through the consumer web portal.

Simple Access to Your Transportation & Parking Funds

With the Benefits debit card, participants can pay providers at the time of service directly from their Transit & Parking account. Parking & Transit receipts are not required by Discovery Benefits to reimburse claims. We recommend that participants keep receipts for their own records.



Deferred Compensation (Administered by MassMutual)

The City of San Leandro offers you a IRS §457 plan to help you save for your retirement. The best way to plan for retirement is to participate in a deferred compensation vehicle, such as a §457 plan.

The money you elect to put into your 457 plan will be deducted from your paycheck on a pre-tax basis and will supplement your CalPERS retirement account.

The IRS annual limit for contributions into your 457 in 2015* are \$18,000. If you are over 50, the 2015* Catch-Up Limit is an additional \$6,000.

Lauren Penko
lpenko@massmutual.com
(888) 593-0259
<http://retirement.massmutual.com/>

**The 2016 limits have not been released as of September 2, 2015. Please check with Finance for the 2016 limits.*



Contact Information

Anthem Blue Cross Select and Traditional HMO		Delta Dental	
Member Services Group Number Website	(855) 839-4524 #HNB050B (Select) #HTB050B (Traditional) www.anthem.com/ca/calpers/hmo	Member Services Group Number Website	(800) 765-6003 #16784 www.deltadentalins.com
Blue Shield Access+ and Net Value HMO		EyeMed Vision	
Member Services Group Number Website	(800) 334-5847 #ITB010B (Access+) #INB010B (NetValue) www.blueshieldca.com/calpers	Member Services Group Number Website	(866) 939-3633 #9739624 www.eyemedvisioncare.com
Kaiser Permanente HMO		Sun Life Financial Life and Disability	
Member Services Group Number Website	(800) 464-4000 #00003-20 www.kp.org/ca/calpers	Member Services Group Number Website	(800) 247-6875 #11562 www.sunlife-usa.com
UnitedHealthcare Alliance HMO		Travel Assist America	
Member Services Group Number Website	(877) 359-3714 #246320 www.uhc.com/calpers	Member Services Group Number Website	(800) 872-1414 (US) (301) 656-4152 (outside US) #01-AA-SUL-100101 www.assistamerica.com
Health Net SmartCare HMO		MHN EAP	
Member Services Group Number Website	(800) 737-7776 #JNB050C www.healthnet.com/calpers	Member Services Group Number Website	(800) 242-6220 #1285 members.mhn.com Company Code: sanleandro
Anthem Blue Cross		Discovery Benefits FSA & TSA	
Member Services Group Number Website	(877) 737-7776 #SB050K (PERS Select) #CB050A (PERS Choice) #KB050A (PERSCare) www.anthem.com/ca/calpers	Member Services Group Number Website	(866) 451-3399 #16856 www.discoverybenefits.com
Anthem Blue Cross PORAC		MassMutual Deferred Compensation	
Member Services Group Number Website	(800) 937-6722 #13079 www.porac.org	Member Services Group Number Website	(888) 593-0259 n/a http://retirement.massmutual.com/



Additional Information Regarding Your Benefits

The following pages are mandatory notices that all employers are required to provide to their employees. The contents of the messages may or may not apply to you. If you have any questions about these notices, please contact Human Resources at (510) 577-3396.

The Newborns and Mothers Health Protection Act

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

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act ("WHCRA") requires employer groups to notify participants and beneficiaries of the Group Health Plan (the "Plan"), of their rights to mastectomy benefits under the Plan. Participants and beneficiaries have rights to coverage to be provided in a manner determined in consultation with the attending Physician for:

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

These benefits are subject to the same deductible and co-payments applicable to other medical and surgical benefits provided under this Plan. For further details, please refer to the Plan's Summary Plan Description.

Health Insurance Portability & Accountability Act (HIPAA)

Notice of Availability of HIPAA Privacy Notice

The Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we periodically remind you of your right to receive a copy of the City of San Leandro's HIPAA Privacy Notice. You can request a copy of the Privacy Notice by contacting Human Resources.

HIPAA Privacy Notices that pertain to other City of San Leandro health plans may be obtained by contacting your insurance carrier directly, at the address provided in the Evidence of Coverage booklets.



Additional Information Regarding Your Benefits

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, you can 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, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Website: https://www.flmedicaidprecovery.com/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-404-656-4507
COLORADO – Medicaid	INDIANA – Medicaid
Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943	Website: http://www.in.gov/fssa Phone: 1-800-889-9949



Additional Information Regarding Your Benefits

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

IOWA – Medicaid	MONTANA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
KANSAS – Medicaid	NEBRASKA – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
KENTUCKY – Medicaid	NEVADA – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	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: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604



Additional Information Regarding Your Benefits

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

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid and CHIP	VERMONT – Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	WASHINGTON – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa www.cms.hhs.gov
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)



Additional Information Regarding Your Benefits

Medicare Part D

Important Notice from the City of San Leandro 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 San Leandro 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 has determined that the prescription drug coverage offered by the City of San Leandro 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 through 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.



Additional Information Regarding Your Benefits

Important Notice from the City of San Leandro About Your Prescription Drug Coverage and Medicare

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 San Leandro coverage will not be affected. The City provided prescription plan is credible and Medicare eligible's are allowed to purchase additional prescription drug coverage through Medicare. See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at <http://www.cms.hhs.gov/CreditableCoverage/>), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current City coverage, be aware that you and your dependents may not 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 San Leandro and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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



Additional Information Regarding Your Benefits

Important Notice from the City of San Leandro About Your Prescription Drug Coverage and Medicare

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person below or contact the City of San Leandro Human Resources Department..

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: January 1, 2016
Name of Entity: City of San Leandro
Contact: Laurie Bockhaus
Address: 835 East 14th Street, San Leandro, CA 94577
Phone: (510) 577-3396



Additional Information Regarding Your Benefits

New Health Insurance Marketplace Coverage Options

Part A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy private individual health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage we offer to you. Please note that this notice is informational only.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find private individual health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2015 for coverage starting as early as January 1, 2016.

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 coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does the Employment-Based Health Coverage We Offer to You Affect Your Eligibility for Premium Savings through the Marketplace?

Yes. If we have offered you health coverage that meets certain standards, you will not be eligible for a tax credit through the Marketplace and you may wish to enroll in our health plan, if you are eligible. (Just because you received this Marketplace notice does not mean you are eligible.) However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if we do not offer coverage to you at all or do not offer coverage that meets certain standards. If the cost of self-only coverage under our health plan is more than 9.5% of your household income for the year, or if our health plan does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting our health plan coverage, then you may lose our contribution (if any) to your coverage under our health plan. Also, our contribution—as well as your employee contribution—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.

How Can I Get More Information About the Health Insurance Marketplace?

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



Additional Information Regarding Your Benefits

New Health Insurance Marketplace Coverage Options

Part B: Information About Employer-Provided Health Plan Coverage

If you decide to complete an application for coverage in the Marketplace, you will be asked for information about our health plan coverage. The information below can help you complete your application for coverage in the Marketplace.

1. General Employer Information.

Employer Name:	City of San Leandro
Employer Identification Number (EIN):	94-6000421
Employer Street Address:	835 East 14th Street
Employer Phone Number:	(510) 577-3396
Employer City:	San Leandro
Employer State:	CA
Employer ZIP Code:	94577
Who Can We Contact About Employee Health Coverage At This Job?	Laurie Bockhaus
Phone Number (if different from above):	
Email Address:	lbockhaus@sanleandro.org

2. Eligibility. You may be asked whether or not you are currently eligible for our health plan coverage or whether you will become eligible for coverage within the next three months. In addition, if you are or will become eligible, you may be required to list the names of your dependents that are eligible for coverage under our health plan.

If you would like information about the eligibility requirements for our health plan, please read the eligibility provisions described in the Summary Plan Description for our health plan. You can obtain a copy of the Summary Plan Description by contacting Laurie Bockhaus at (510) 577-3396.

3. Minimum Value. If you are eligible for coverage under our health plan, you may be required to check a box indicating whether or not our health plan meets the minimum value standard. Our health plan coverage meets the minimum value standard.



Additional Information Regarding Your Benefits

New Health Insurance Marketplace Coverage Options

4. Premium Cost. If you are eligible for coverage under our health plan, you may be asked to provide the amount of premiums you must pay for self-only coverage under the lowest-cost health plan that meets the minimum value standard. If you had the opportunity to receive a premium discount for any tobacco cessation program, you must enter the premium you would pay if you received the maximum discount possible for a tobacco cessation program.

If you would like information about the premiums for self-only coverage under our lowest-cost health plan, please contact Laurie Bockhaus at (510) 577-3396.

5. Future Changes. You may also be asked whether or not we will be making certain changes to our health plan coverage for the new plan year. As usual, you will be provided with information about any changes to our health plan coverage before the next open enrollment period. If you are not sure how to answer this question on your Marketplace application, please contact the Marketplace.



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The information in this booklet is a general outline of the benefits offered under the City of San Leandro benefits program. Specific details and plan limitations are provided in the Evidence of Coverage (EOC), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The EOC and Plan Documents contain all the specific provisions of the plans. In the event that information in this booklet differs from the Plan Documents, the Plan Documents will prevail.

Employee Benefits Overview designed and developed by



in conjunction with the City of San Leandro, Fall 2014

Human Resources
835 East 14th Street
San Leandro, CA 94577
(510) 577-3396