2021

Employee Benefits Overview

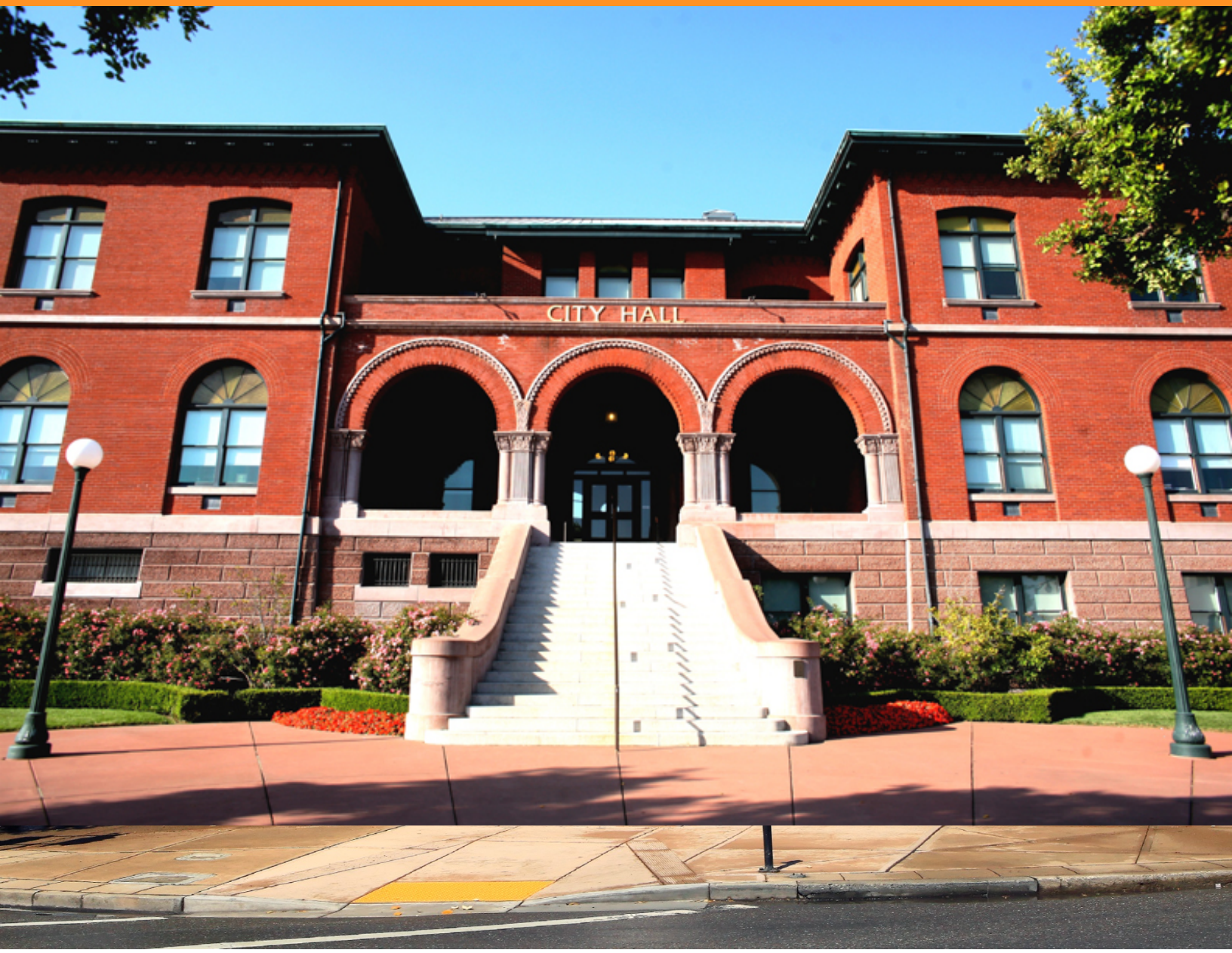
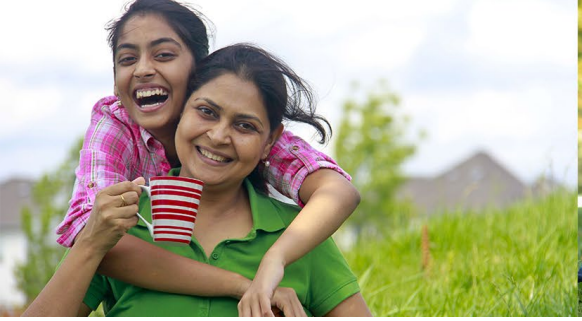
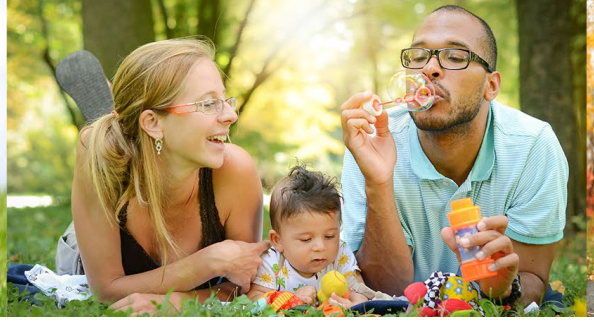


TABLE OF CONTENTS

Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices of 2021 for more details at the end of this booklet.


Focus on Benefits

At City of Alameda, we believe that you, our employees, are our most important asset. Helping you and your families achieve and maintain good health—physical, emotional and financial—is the reason City of Alameda offers you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts is provided at the back of this summary.

While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

The benefits in this summary are effective:

January 1, 2021 - December 31, 2021

Welcome to the 2021 Benefits Program

The City of Alameda 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 2021 Employee Benefits Overview for eligible employees of the City of Alameda. Please review this guide carefully and retain this guide for the calendar year 2021 as an easy reference to your benefit plan offerings.

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

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

SUMMARY

The information in this booklet is a general outline of the benefits offered under the City of Alameda 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) 747-4900 or jromeo@alameda.gov

Online Resource: https://alamedaca.gov/human-resources

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 21st, 2020 and lasting through October 16th, 2020, 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, 2021 and will run through December 31, 2021. In order to ensure a smooth implementation, **your forms are due no later than October 16th, 2020**!

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?

2021 Action Items

What you need to do this year for the 2021 plan year are highlighted below.

Plan	Action
Discovery Benefits FSA	If you want a Flexible Spending Account next year, you'll need to set up or renew your contributions.

Who Can You Cover

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.

When Can You 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.

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) 747-4900.

Making the Most of Your Benefits Program

Helping you and your family members stay healthy and making sure you use your benefits program to its best advantage is our goal in offering this program. Here are a few things to keep in mind.

STAY WELL!

Harder than it sounds, of course, but many health problems are avoidable. Take action—from eating well, to getting enough exercise and sleep. Taking care of yourself takes care of a lot of potential problems.

ASK QUESTIONS AND STAY INFORMED

Know and understand your options before you decide on a course of treatment. Informed patients get better care. Ask for a second opinion if you're at all concerned.

GET A PRIMARY CARE PROVIDER

Having a relationship with a PCP gives you a trusted person who knows your unique situation when you're having a health issue. Visit your PCP or clinic for non-emergency healthcare.

GOING TO THE DOCTOR?

To get the most out of your doctor visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of what you want to talk about with your doctor

If you need a medication, you could save money by asking your doctor if there are generics or generic alternatives for your specific medication.

AN APPLE A DAY

Eating moderately and well really does help keep the doctor away. Stay away from fat-heavy, processed foods and instead focus on whole grains, vegetables, and lean meats to be the healthiest you can be.

USING THE EMERGENCY ROOM

Did you know most ER visits are unnecessary? Use them only in a true emergency—like any situation where life, limb, and vision are threatened. Otherwise, call your doctor, your nurse line, or go to an Urgent Care clinic. You'll save a lot of money and time.

BE MED WISE!

Always follow your doctor's and pharmacist's instructions when taking medications. You can worsen your condition(s) by not taking your medication or by skipping doses. If your medication is making you feel worse, contact your doctor.

Medical

The goal of the City of Alameda 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, UnitedHealthcare, and Western Health Advantage (WHA)

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, UnitedHealthcare Alliance and Western Health Advantage 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 4, 2019 to ensure enrollment and for coverage to be effective January 1, 2021.

For a summary of the different plans, and additional information please review the CalPERS Open Enrollment site at www.calpers.ca.gov. There you will find the Health Benefits Summary, Health Program Guide, and additional resources and information regarding your CalPERS Health Plan options.

Medical – HMO

Medical coverage provides you with benefits that help keep you healthy like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition. City of Alameda provides you with comprehensive coverage through CalPERS.

	Anthem BlueCross	Kaiser Permanente	Health Net	United Healthcare	Western Health Advantage
	In-Network	In-Network	In-Network	In-Network	In-Network
Annual Deductible					
Individual	$0	$0	$0	$0	$0
Family	$0	$0	$0	$0	$0
Annual Out-of-Pocket Max (excluding pharmacy)					
Individual	$1,500	$1,500	$1,500	$1,500	$1,500
Family	$3,000	$3,000	$3,000	$3,000	$3,000
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Office Visit					
Primary Provider	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay
Specialist	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Chiropractic and Acupuncture Care	$15 copay (max 20 visits combined)	$15 copay (max 20 visits combined)	$15 copay (max 20 visits combined)	$15 copay (max 20 visits combined)	$15 copay (max 20 visits combined)
Lab and X-ray	No Charge	No Charge	No Charge	No Charge	No Charge
Inpatient Hospitalization	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient Surgery	No Charge	No Charge	$15 copay	No Charge	No Charge
Urgent Care	$15 copay	$15 copay	$15 copay	$15 copay	$15 copay
Emergency Room	$50 copay (copay waived if admitted)	$50 copay (copay waived if admitted)	$50 copay	$50 copay (copay waived if admitted)	$50 copay (copay waived if admitted)

For 2021, the Affordable Care Act (ACA) limits out-of-pocket maximums (OOPM) amounts for health plans to $8,550 (individual) and $17,100 (family) for both medical and pharmacy benefits combined.

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 summary differs from the Plan Documents, the Plan Documents will prevail.

Medical – PPO

	Anthem BlueCross Choice & Select PPO		Anthem BlueCross PERS Care PPO	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Annual Deductible Individual Family	 $500 $1,000	 $500 $1,000	 $500 $1,000	 $500 $1,000
Annual Out-of-Pocket Max (excluding pharmacy) Individual Family	 $3,000 $6,000	 None None	 $2,000 $4,000	 None None
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited
Office Visit				
Primary Provider	$20 copay	40% coinsurance	$20 copay	40% coinsurance
Specialist	$20 copay	40% coinsurance	$20 copay	40% coinsurance
Preventive Services	No Charge	40% coinsurance	No Charge	40% coinsurance
Acupuncture/Chiropractic combined 20 visits per year	$15 copay	40% coinsurance	$15 copay	40% coinsurance
Lab and X-ray	20% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Inpatient Hospitalization	20%-30% coinsurance	40% coinsurance	$250 per admit deductible then 10%	$250 per admit deductible then 40%
Outpatient Surgery	20%-30% coinsurance	40% coinsurance	$250 per admit deductible then 10%	$250 per admit deductible then 40%
Urgent Care	$20 copay	40% coinsurance	$20 copay	40% coinsurance
Emergency Room	$50 copay then 20% coinsurance (copay waived if admitted)	$50 copay then 20% coinsurance (copay waived if admitted)	$50 copay then 10% coinsurance (copay waived if admitted)	$50 copay then 10% coinsurance (copay waived if admitted)

For 2021, the Affordable Care Act (ACA) limits out-of-pocket maximums (OOPM) amounts for health plans to $8,550 (individual) and $17,100 (family) for both medical and pharmacy benefits combined.

Specific details and plan limitations are provided in the Evidence of Coverage, which is based on the official Plan Documents that may include policies, contracts, and plan procedures. The Plan Documents contain all the specific provisions of the plans. In the event that the information in this summary differs from the Plan Documents, the Plan Documents will prevail.

Medical – PORAC

Anthem BlueCross

PORAC PPO

	In-Network	Out-Of-Network
Annual Deductible Individual Family	 $300 $900	 $600 $1,800
Annual Out-of-Pocket Max (excluding pharmacy) Individual Family	 $3,000 $6,000	 Combined with In-Network OOP Max Combined with In-Network OOP Max
Lifetime Max	Unlimited	Unlimited
Office Visit		
Primary Provider	$20 copay	10% of limited fee schedule
Specialist	$20 copay	10% of limited fee schedule
Preventive Services	No Charge	10% of limited fee schedule
Acupuncture/Chiropractic combined 20 visits per year	$20 copay	10% of limited fee schedule
Lab and X-ray	10%	10% of limited fee schedule
Inpatient Hospitalization	10%	10% of limited fee schedule
Outpatient Surgery	10%	10% of limited fee schedule
Urgent Care	10%	10% of limited fee schedule
Emergency Room	$75 copay (copay waived if admitted)	10% of limited fee schedule (copay waived if admitted)

For 2021, the Affordable Care Act (ACA) limits out-of-pocket maximums (OOPM) amounts for health plans to $8,550 (individual) and $17,100 (family) for both medical and pharmacy benefits combined.

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 summary differs from the Plan Documents, the Plan Documents will prevail.

Prescription Drugs – HMO

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure.

If you enroll in medical coverage, you will automatically receive coverage for prescription drugs. Here are the prescription drug plans that are offered with our CalPERS Medical plans. Please note for HMO plans, out of network prescriptions are not covered, it will be 100% out of pocket.

	Anthem BlueCross	Health Net	Kaiser Permanente	United Healthcare	Western Health Advantage
	In-Network	In-Network	In-Network	In-Network	In-Network
Prescription Drug Deductible	$0	$0	$0	$0	$0
Pharmacy[1]					
Generic	$5 copay	$5 copay	$5 copay	$5 copay	$5 copay
Preferred Brand	$20 copay	$20 copay	$20 copay	$20 copay	$20 copay
Non-preferred Brand	$50 copay	$50 copay	$20 copay	$50 copay	$50 copay
Supply Limit	30 days	30 days	30 days	30 days	30 days
Pharmacy Annual Out-of-Pocket Limit					
Individual	$ 5,850	$ 5,850	$ 5,850	$ 5,850	$ 5,850
Family	$11,700	$11,700	$11,700	$11,700	$11,700
Mail Order & After 1st Fill					
Generic	$10 copay	$10 copay	$10 copay	$10 copay	$10 copay
Preferred Brand	$40 copay	$40 copay	$40 copay	$40 copay	$40 copay
Non-preferred Brand	$100 copay	$100 copay	Not Applicable	$100 copay	$100 copay
Supply Limit	90 days	90 days	100 days	90 days	90 days
Mail Order Annual Out-of-Pocket Limit	$1,000	$1,000	N/A	N/A	$1,000

[1]1st Fill Only

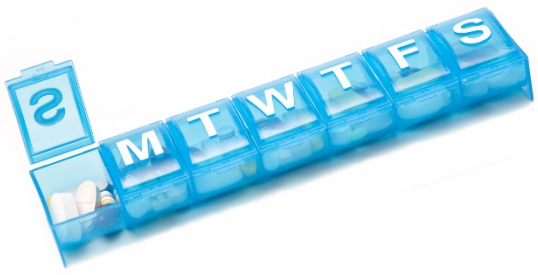
Specific details and plan limitations are provided in the Evidence of Coverage, which is based on the official Plan Documents that may include policies, contracts, and plan procedures. The Plan Documents contain all the specific provisions of the plans. In the event that the information in this summary differs from the Plan Documents, the Plan Documents will prevail.

Prescription Drugs – PPO

	PERS Choice & Select PPO		PERS Care PPO	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Prescription Drug Deductible	$0	$0	$0	$0
Pharmacy[1]				
Generic	$5 copay	Not Covered (100% out of pocket)*	$5 copay	Not Covered (100% out of pocket)*
Preferred Brand	$20 copay	Not Covered (100% out of pocket)*	$20 copay	Not Covered (100% out of pocket)*
Non-preferred Brand	$50 copay	Not Covered (100% out of pocket)*	$50 copay	Not Covered (100% out of pocket)*
Supply Limit	30 days	Not Covered (100% out of pocket)*	34 days	34 days
Pharmacy Annual Out-of-Pocket Limit				
Individual	$2,000	$2,000	$2,000	$2,000
Family	$4,000	$4,000	$4,000	$4,000
Mail Order & After 1st Fill				
Generic	$10 copay	Not Covered (100% out of pocket)*	$10 copay	Not Covered (100% out of pocket)*
Preferred Brand	$40 copay	Not Covered (100% out of pocket)*	$40 copay	Not Covered (100% out of pocket)*
Non-preferred Brand	$100 copay	Not Covered (100% out of pocket)*	$100 copay	Not Covered (100% out of pocket)*
Supply Limit	90 days	Not Covered (100% out of pocket)*	90 days	Not Covered (100% out of pocket)*
Mail Order Annual Out-of-Pocket Limit	$1,000	$1,000	$1,000	$1,000

[1]1st Fill Only
*Paper claims may be submitted to request partial reimbursement

Specific details and plan limitations are provided in the Evidence of Coverage, which is based on the official Plan Documents that may include policies, contracts, and plan procedures. The Plan Documents contain all the specific provisions of the plans. In the event that the information in this summary differs from the Plan Documents, the Plan Documents will prevail.



Prescription Drugs – PORAC

Anthem BlueCross

PORAC PPO

	In-Network	Out-Of-Network
Prescription Drug Deductible	$0	$0
Pharmacy		
Generic	$10 copay	100% up-front cost to individual*
Preferred Brand	$25 copay	
Non-preferred Brand	$45 copay	
Supply Limit	30 days	30 days
Pharmacy Annual Out-of-Pocket Limit		
Individual	$3,000	
Family	$6,000	
Mail Order		
Generic	$20 copay	Not covered
Preferred Brand	$40 copay	Not covered
Non-preferred Brand	$75 copay	Not covered
Supply Limit	90 days	Not applicable

*Paper claims may be submitted to request partial reimbursement

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 summary differs from the Plan Documents, the Plan Documents will prevail.

Dental

Preferred Provider Organization (PPO) and Premier

Under the Delta Dental Premier Plus 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 charge you 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.

Please note that Delta Dental does not issue identification cards, but you can print one on your own by registering for a personal account on www.deltadentalins.com (click on My ID card).

	Delta Dental (PRISM) Dental PPO Plan Safety		Delta Dental (PRISM) Dental PPO Plan Miscellaneous	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Calendar Year Deductible	$0 per individual $0 per family	$0 per individual $0 per family	$0 per individual $0 per family	$0 per individual $0 per family
Annual Plan Maximum	$2,600 per individual	$2,500 per individual (combined with in-network)	$2,600 per individual	$2,500 per individual (combined with in-network)
Waiting Period	None	None	None	None
Diagnostic and Preventive	Plan pays 90%	Plan pays 90%	Plan pays 80%	Plan pays 80%
Basic Services				
Fillings	Plan pays 90%	Plan pays 90%	Plan pays 80%	Plan pays 80%
Root Canals	Plan pays 90%	Plan pays 90%	Plan pays 80%	Plan pays 80%
Periodontics	Plan pays 90%	Plan pays 90%	Plan pays 80%	Plan pays 80%
Major Services	Prosthodontics: plan pays 50%; all others: plan pays 80%	Prosthodontics: plan pays 50%; all others: plan pays 80%	Prosthodontics: plan pays 50%; all others: plan pays 80%	Prosthodontics: plan pays 50%; all others: plan pays 80%
Orthodontic Services				
Orthodontia	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%
Lifetime Maximum	$2,500 per individual	$2,500 per individual (combined with in-network)	$2,500 per individual	$2,500 per individual (combined with in-network)
Dependent Children	Covered	Covered	Covered	Covered
Full-time Students	Covered	Covered	Covered	Covered

Dental, continued

Here is an overview of our third dental plan, a plan offered through Delta Dental of California.

Delta Dental (PRISM) Dental PPO Plan Retirees

	In-Network	Out-Of-Network
Calendar Year Deductible	$0 per individual $0 per family	$0 per individual $0 per family
Annual Plan Maximum	$2,600 per individual	$2,500 per individual (combined with in-network)
Waiting Period	None	None
Diagnostic and Preventive	Plan pays 90%	Plan pays 90%
Basic Services		
Fillings	Plan pays 90%	Plan pays 90%
Root Canals	Plan pays 90%	Plan pays 90%
Periodontics	Plan pays 90%	Plan pays 90%
Major Services	Prosthodontics: plan pays 50%; all others: plan pays 80%	Prosthodontics: plan pays 50%; all others: plan pays 80%
Orthodontic Services		
Orthodontia	Plan pays 50%	Plan pays 50%
Lifetime Maximum	$2,500 per individual	$2,500 per individual (combined with in-network)
Dependent Children	Covered	Covered
Full-time Students	Covered	Covered

* 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 (VSP)

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions.

You are eligible for vision coverage through Vision Service Plan (VSP). VSP provides coverage for eye exams and materials, such as lenses and frames.

Voluntary Vision (PRISM) Plan

	In-Network	Out-Of-Network
Examination		
Benefit	$10 copay then plan pays 100%	$45 allowance
Frequency	1 x every 12 months	In-network limitations apply
Eyeglass Lenses		
Single Vision Lens	$25	$30 allowance
Bifocal Lens	$25	$50 allowance
Trifocal Lens	$25	$65 allowance
Frequency	1 x every 12 months	In-network limitations apply
Frames		
Benefit	$150 plan pays (20% discount over allowed amount)	$70 allowance
Frequency	1 x every 12 months	In-network limitations apply
Contacts (Elective)		
Benefit	Up to $150	Up to $105 (instead of eyeglasses)
Frequency	1 x every 12 months	1 x every 12 months

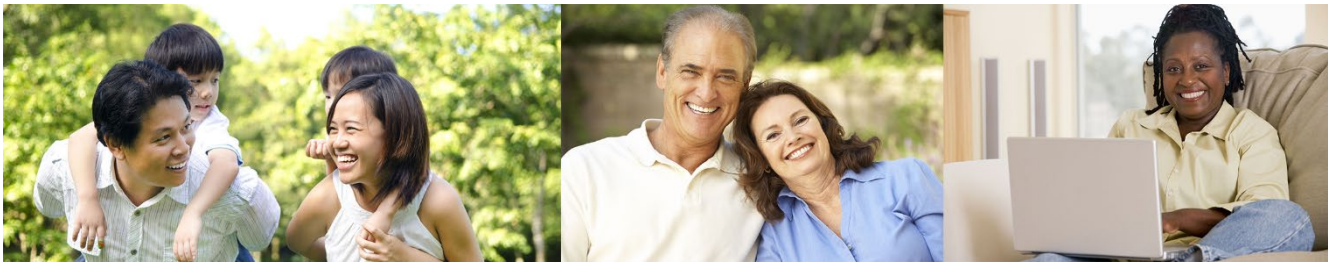
*Materials copay: When purchasing eyewear, a $25 or $10 copay will be required, depending on the plan you select.

**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 $150 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 Insurance (Voya)

Basic Life insurance provides income protection for your beneficiary in the event of your death. The City of Alameda 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 AND AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by the company. Coverage is provided by Voya.

Class Type	Description	Basic Life and AD&D Amount
Class 1	Elected Officials	$15,000
Class 2	All full-time employees under PANS, IBEW, APOA, IAFF	$50,000
Class 3	All full-time employees under MCEA, 3APT, EXME, AFMA, APMA and ACEA	$100,000

VOLUNTARY LIFE

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Voya

Employee Voluntary Life Amount	Increments of $10,000 Guarantee Issue: $240,000 Maximum Issue: $500,000 (Not to exceed 5 times annual earnings)
Spouse Voluntary Life Amount	Increments of $5,000 Guarantee Issue: $30,000 Maximum Issue: $100,000 (Not to exceed 1x the employee benefit)
Child(ren) Voluntary Life Amount	Minimum: $1,000 (From age 14 days to 6 months.) Maximum: $10,000 (In increments of $1,000 from 6 months to 26 years)

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

VOLUNTARY LIFE INSURANCE RATE CALCULATION — ACTIVE EMPLOYEE AND SPOUSE / DEPENDENT RATES

You may elect up to **$500,000** of Supplemental Life Insurance for yourself, in increments of $10,000. You are guaranteed coverage for $240,000 if under age 70, and $10,000 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 **$100,000** of Supplemental Life Insurance for your spouse/domestic partner, in increments of $5,000 (not to exceed 1 x employee benefit). Your spouse/domestic partner is guaranteed coverage for $30,000.

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 $1,000 Unit)
Under Age 29	$0.032
30-34	$0.044
35-39	$0.069
40-44	$0.113
45-49	$0.198
50-54	$0.332
55-59	$0.588
60-64	$0.922
65-69	$1.67
70+	$3.55

To calculate the monthly premium:

1. Amount Elected: Write the amount of units you want. (1 unit = $1,000) 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 =
250 x $0.113= $28.25/monthly premium

VOLUNTARY LIFE INSURANCE RATE CALCULATION — DEPENDENT CHILD(REN) RATES

Your dependent child is covered at **$1,000** or **$10,000** of Supplemental Life Insurance per child. See rates below.

Child Age	Benefit	Monthly Cost:
0 to 14 days	None	None
15 days to 6 months	$1,000 for each child	$2.00
6 months to 19 years	$10,000 for each child	$2.00

Disability Insurance (Voya)

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

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 Alameda's LTD plan.

LONG-TERM DISABILITY INSURANCE (LTD)

Long-Term Disability coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security.

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 monthly benefit or a minimum monthly benefit of $100

Eligibility	Class 1: All full-time Department Heads (EXME & 3APT) and all other full-time employees excluding Sworn Police & Sworn Fire Department	Class 2: All Other full-time employees excluding Sworn Police Department & Sworn Fire Department
Elimination Period	90 Days	90 Days
Monthly Benefit	66.67% of monthly earnings	66.67% of monthly earnings
Maximum Monthly Benefit	$8,000	$1,667
Minimum Monthly Benefit	$100	$100

*The age at which the disability begins may affect the duration of the benefit

Flexible Spending Account (FSA)

HEALTH CARE FSA ACCOUNT

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. The catch is that you have to use the money in your account by December 31, 2021. Otherwise, that money is lost, so plan carefully. However, you are allowed to utilize the Grace Period until March 15th of the following plan year. You must re-enroll in this program each year. Discovery Benefits, Inc. administers this program.

IMPORTANT CONSIDERATIONS

- Expenses must be incurred between 01/01/21 and 12/31/21 and submitted for reimbursement no later than 03/31/22.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- The FSA plan includes a "**Grace Period**" provision, which allows you to incur and claim eligible expenses until March 15th of the following year. FSA funds can be used for you, your spouse, and your tax dependents only.
- You can obtain reimbursement for eligible expenses incurred by your spouse or tax dependent children, even if they are not covered on the City of Alameda health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).
- Keep your receipts. In most cases, you'll need to provide proof that your expenses were considered eligible for IRS purposes.

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, The FSA plan includes a "Grace Period" provision, which allows you to incur and claim eligible expenses until March 15th of the following year.

This plan allows you to pay for eligible out-of-pocket healthcare expenses with pre-tax dollars. Eligible expenses include medical, dental, or vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents.

You may access your entire annual election from the first day of the plan year and you can set aside up to **$2,750** this year.

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

Flexible Spending Account (FSA)

DEPENDENT CARE FSA ACCOUNT

This plan allows you to set aside pre-tax dollars that can be used to help pay for day care services for eligible dependents. The maximum amount you can contribute to this plan annually is $5,000 (if you are married but filing separately, federal regulations limit the use of a Dependent Care FSA to $2,500 each year). In order to qualify for Dependent Care FSA the IRS has established the following regulations:

- An eligible dependent is any child under the age of 13 or a dependent who is physically or mentally incapable of caring for his or her own needs, such as an invalid parent
- If you claim the dependent care credit on your tax return or collect compensation through your Dependent Care FSA, you must report the name, address, and tax payer identification number of each dependent care provider.

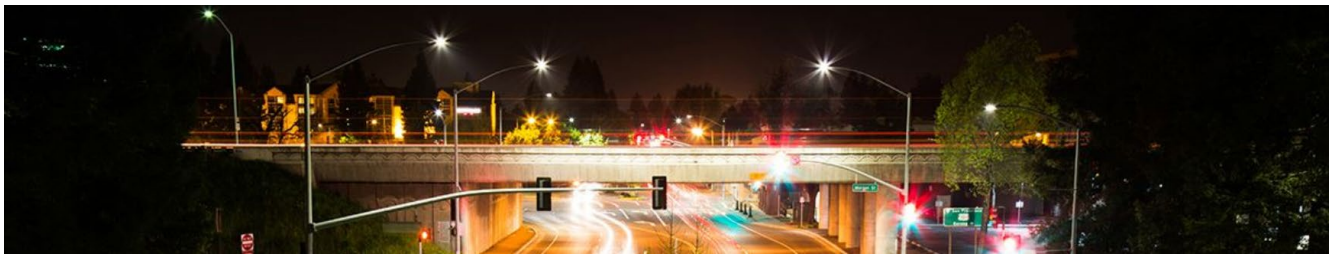
Dependent Care FSA Eligible Expenses*:

- Care for your child who is under age 13 before and after-school care
- Baby sitting and nanny expenses
- Day care, nursery school, and preschool
- Summer day camp
- Care for a relative who is physically or mentally incapable of self-care and lives in your home

* For more information about your FSA options please visit Discovery Benefits' website
www.discoverybenefits.com

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can set aside up to $5,000 per household for eligible dependent care expenses for the year.

Transportation Spending Account (TSA)



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 $270 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 $270 per month can be contributed on pre-tax basis.

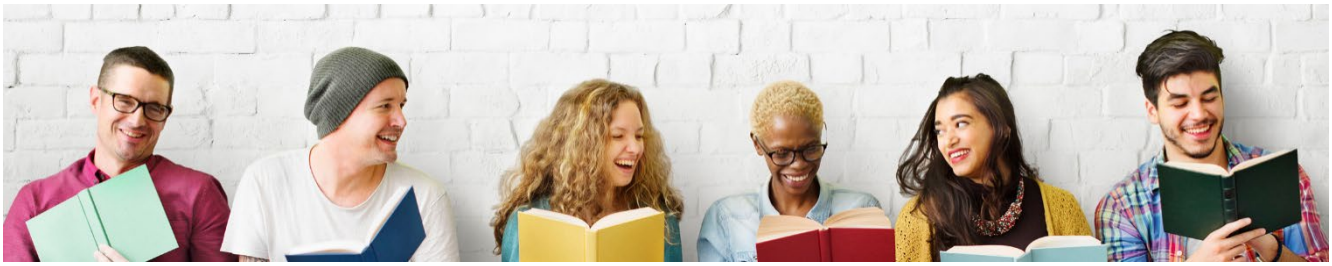
If the parking facility does not accept debit card payments, participants may also pay out of pocket and then submit a claim online through the consumer web portal.

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.

* For more information about your TSA options please visit Discovery Benefits' website
www.discoverybenefits.com

Employee Assistance Program (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 ten (10) 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
Use Group Code: alameda

Contact Information

If you need to reach our plan providers, here is their contact information:

Anthem Blue Cross Select and Traditional HMO	
Member Services	(855) 839-4524
Group Number	#HNB05B (Select) #HTB050B (Traditional)
Website	www.anthem.com/ca/calpers/hmo

Delta Dental of California	
Member Services	(800) 765-6003 (PPO)
Group Number	#16784
Website	www.deltadentalins.com

Blue Shield Access+ HMO	
Member Services	(800) 334-5847
Group Number	#ITB010B (Access+) #INB010B (Net Value)
Website	www.blueshieldca.com/calpers

VSP Vision	
Member Services	(800) 877-7195
Group Number	#0250/0251
Website	www.vsp.com

Kaiser Permanente HMO	
Member Services	(800) 464-4000
Group Number	#00003-20
Website	www.kp.org/ca/calpers

Voya	
Member Services	(800) 955-7736
Group Number	#31640-7
Website	www.voya.com

UnitedHealthcare Alliance HMO	
Member Services	(877) 359-3714
Group Number	#246320
Website	www.uhc.com/calpers

AFLAC	
Member Services	(800) 872-1414 (US)
Group Number	N/A
Website	www.aflac.com

Health Net SmartCare HMO	
Member Services	(888) 926-4921
Group Number	#JNB050C
Website	www.heathnet.com/calpers

MHN EAP	
Member Services	(800) 242-6220
Group Code	alameda
Website	www.mhn.com

Anthem Blue Cross PORAC	
Member Services	(800) 937-6722
Group Number	#13079
Website	www.porac.org

Discovery Benefits FSA & TSA	
Member Services	(866) 451-3399
Group Number	#16856
Website	www.discoverybenefits.com

Anthem Blue Cross PERS Select, PERS Choice	
Member Services	(877) 737-7776
Group Number	#SB050K (PERS Select) #CB050A (PERS Choice) #KB050A (PERSCare)
Website	www.anthem.com/ca/calpers

Key Terms

MEDICAL/GENERAL TERMS

Allowable Charge - The most that an in-network provider can charge you for an office visit or service.

Balance Billing - Non-network providers are allowed to charge you more than the plan's allowable charge. This is called Balance Billing.

Coinsurance - The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible for paying the remaining 30% of the cost.

Copay - The fee you pay to a provider at the time of service.

Deductible - The amount you have to pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

Explanation of Benefits (EOB) - The statement you receive from the insurance carrier that explains how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay a bill from your provider until you have received and reviewed your EOB (except for copays).

In-Network - Services received from providers (doctors, hospitals, etc.) who are a part of your health plan's network. In-network services generally cost you less than out-of-network services.

Out-of-Network - Services received from providers (doctors, hospitals, etc.) who are not a part of your health plan's network. Out-of-network services generally cost you more than in-network services. With some plans, such as HMOs and EPOs, out-of-network services are not covered.

Out-of-Pocket - Healthcare costs you pay using your own money, whether from your bank account, credit card, Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Out-of-Pocket Maximum – The most you would pay out-of-pocket for covered services in a year. Once you reach your out-of-pocket maximum, the plan covers 100% of eligible expenses.

Preventive Care – A routine exam, usually yearly, that may include a physical exam, immunizations and tests for certain health conditions.

PRESCRIPTION DRUG TERMS

Brand Name Drug - A drug sold under its trademarked name. A generic version of the drug may be available.

Generic Drug – A drug that has the same active ingredients as a brand name drug, but is sold under a different name. Generics only become available after the patent expires on a brand name drug. For example, Tylenol is a brand name pain reliever commonly sold under its generic name, Acetaminophen.

Dispense as Written (DAW) - A prescription that does not allow for substitution of an equivalent generic or similar brand drug.

Maintenance Medications - Medications taken on a regular basis for an ongoing condition such as high cholesterol, high blood pressure, asthma, etc. Oral contraceptives are also considered a maintenance medication.

Non-Preferred Brand Drug - A brand name drug for which alternatives are available from either the plan's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.

Preferred Brand Drug - A brand name drug that the plan has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of clinical effectiveness and cost.

Specialty Pharmacy - Provides special drugs for complex conditions such as multiple sclerosis, cancer and HIV/AIDS.

Step Therapy - The practice of starting to treat a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

DENTAL TERMS

Basic Services - Generally include coverage for fillings and oral surgery.

Diagnostic and Preventive Services - Generally include routine cleanings, oral exams, x-rays, sealants and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Endodontics - Commonly known as root canal therapy.

Implants - An artificial tooth root that is surgically placed into your jaw to hold a replacement tooth or bridge. Many dental plans do not cover implants.

Major Services - Generally include restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Orthodontia - Some dental plans offer Orthodontia services for children (and sometimes adults too) to treat alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.

Periodontics - Diagnosis and treatment of gum disease.

Pre-Treatment Estimate - An estimate of how much the plan will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

Important Plan Notices

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 HIPAA Privacy Notice. You can request a copy of the Privacy Notice by contacting Human Resources.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR MEDICAL/HEALTH PLAN COVERAGE

If you decline enrollment in a City of Alameda health plan for your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in a City of Alameda health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in a City of Alameda health plan if your dependent becomes eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another health plan.

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, 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;
- Prostheses; 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 our plans. If you would like more information on WHCRA benefits, call your plan administrator.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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

AVAILABILITY OF SUMMARY INFORMATION

As an employee, the health benefits provided by City of Alameda represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

City of Alameda offers a variety of benefit plans to eligible employees. The federal health care reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by City of Alameda are available by contacting Human Resources.

NOTICE OF CHOICE OF PROVIDERS

HMO plans generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. Until you make this designation, your carrier 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, contact your insurance carrier direct.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of August 1, 2019. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218

KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002

VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since August 1, 2020, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 12/31/2019)

MEDICARE PART D

Important Notice from the City of Alameda 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 Alameda 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 Alameda 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.

Important Notice from the City of Alameda 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 Alameda 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 Alameda and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person below or contact the City of Alameda 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, 2021
Name of Entity:	City of Alameda
Contact:	Jessica Romeo
Address:	2263 Santa Clara Ave, Alameda, CA - 94501
Phone:	(510) 747-4900

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

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 Alameda
Employer Identification Number (EIN):	94-6000288
Employer Street Address:	2263 Santa Clara Ave
Employer Phone Number:	(510) 747-4900
Employer City:	Alameda
Employer State:	CA
Employer ZIP Code:	94501
Who Can We Contact About Employee Health Coverage At This Job?	Jessica Romeo
Email Address:	jromeo@alameda.gov

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 Nancy Bronstein at (510) 747-4900.

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.

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 Nancy Bronstein at (510) 747-4900.

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.

This booklet is a general outline of the benefits offered under the City of Alameda 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.

Rev. 9/18/2020

Employee Benefits Overview designed and developed by

Alliant
EMPLOYEE BENEFITS

in conjunction with the City of Alameda, Fall 2020

Human Resources
2263 Santa Clara East Ave
Alameda, CA 94501
(510) 747-4900