Employee Benefits

2021 Guide

OAKLAND POLICE

Sworn Police

CITY OF OAKLAND

Employee Benefits Guide

SWORN POLICE

2021

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

Please see page 31 for more details.

The information in this brochure is a general outline of the benefits offered under the City of Oakland's benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (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.

Employee Benefits Package Overview

- CalPERS Medical
- Dental
- Flexible Spending Accounts
- Commuter Benefits
- Employee Assistance Program (EAP)
- Guaranteed Ride Home (GRH)
- Pension Benefits
- Deferred Compensation

Contact Information

Benefits Contacts

You may contact the below benefit carriers or visit the following websites to confirm eligibility and verify coverage:

Employee Benefits Program	Benefits Representative	Contact Information
Benefits Coordinator	**Tami Honda**	510.238.6891 thonda@oaklandca.gov
Benefits Enrollment Questions New Hire Benefit Enrollment	**Adrienne Cooper**	510.238.6474 acooper2@oaklandca.gov
COBRA	**Denise Carter**	510.238.7446 dcarter@oaklandca.gov
	Administrator: Navia Benefits Solutions	877.920.9675 cobra@naviabenefits.com
Deferred Compensation	**Michael McGhee ICMA-RC** (Investment Option Inquiry Only)	510.238.6485 mmcghee@icmarc.org
	Michael Akanji	510.238.7445 makanji@oaklandca.gov
Medical, Dental & Vision	**Adrienne Cooper**	510.238.6474 acooper2@oaklandca.gov
Other Benefits		
• Flexible Spending Arrangement Program • Health Care FSA • Day Care FSA • Commuter Benefits	**Denise Carter**	510.238.7446 dcarter@oaklandca.gov
• Life Insurance	**Denise Carter**	510.238.7446 dcarter@oaklandca.gov
• Family Medical Leave Act (FMLA) • Pregnancy Disability and Bonding	**Donella Williams**	510.238.6488 dwilliams3@oaklandca.gov
Guaranteed Ride Home	**Tami Honda**	510.238.6891 thonda@oaklandca.gov

Contact Information (continued)

Risk Contacts

Employee Benefits Program	Benefits Representative	Contact Information
Risk Administration	Andrew Lathrop – Manager	510.238.7165 alathrop@oaklandca.gov
• Administrative Support • Safety Shoe Program, Health and Wellness	Erika Turner	510.238.7660 eturner@oaklandca.gov
• Employee Assistance Program • Threat Assessment • CAL/OSHA Programs	Greg Elliott	510.238.4993 gelliott@oaklandca.gov
• Ergonomics • Safety, Health & Wellness • VDT Glasses	Lana Chan	510.238.7971 LChan2@oaklandca.gov
• Risk – Contracts & Insurance	Michael Bailey	510.986.2898 mbailey@oaklandca.gov
• Workers' Compensation • Fair Employment Housing Act (FEHA) • Americans with Disabilities Act (ADA)	Mary Baptiste	510.238.2270 mbaptiste@oaklandca.gov
• Family Medical Leave Act FMLA • State Disability Insurance (1021) • Paid Family Leave *(Non-sworn)* • Unemployment (EDD)	Michael Akanji	510.238.7445 makanji@oaklandca.gov

Contact Information (continued)

You may also contact the below benefit carriers or visit the following websites to confirm eligibility and verify coverage:

Employee Benefits Program	Phone Number	Web Site
Medical		
• CalPERS	888.225.7377	https://my.calpers.ca.gov
Dental		
• OPOA Dental	510.834.9670	renee@opoa.org
Vision		
• OPOA Vision	510.834.9670	
Health Care and Day Care FSA		
• Navia Health Care FSA & Day Care FSA	800.669.3539	https://www.naviabenefits.com **or** customerservice@naviabenefits.com
COBRA Administration		
• Navia COBRA	877.920.9675	cobra@naviabenfits.com
Commuter Benefits		
• GoNavia Commuter Benefits	800.669.3539	https://www.naviabenefits.com
• Guaranteed Ride Home Program	510.433.0320	ridehome@alamedactc.org
Life and Disability Insurance		
• OPOA	510.834.9670	
Employee Assistance Program (EAP)		
• Claremont EAP	800.834.3773	www.claremonteap.com
Deferred Comp		
• ICMA-RC	800.669.7400	https://www.icmarc.org/city-of-oakland-457-plan.html

2021 Payroll Calendar

JANUARY

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31						

FEBRUARY

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JULY

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OCTOBER

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NOVEMBER

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DECEMBER

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2021 Holiday Schedule

2021 Holiday	Date		Day of the Week
	Month	Day	
New Year's Day	January	01	Friday
Dr. Martin Luther King, Jr. Day	January	18	Monday
Lincoln's Birthday	February	12	Friday
President's Day	February	15	Monday
Memorial Day	May	31	Monday
Independence Day	July	04	Sunday
Labor Day	September	06	Monday
Admissions Day	September	09	Thursday
Veterans Day	November	11	Thursday
Thanksgiving Day	November	25	Thursday
Day After Thanksgiving	November	26	Friday
Christmas Day	December	25	Saturday

The Chief or designee shall determine which positions shall be filled on each designated holiday. However, all officers assigned to Patrol shall report to work on any holiday which falls on one of their regularly assigned work days unless the officer has the day off through the holiday or vacation draw.

All qualifying OPOA employees will be paid straight time for the full length of their regularly scheduled shift for each holiday. In order to qualify for receipt of compensation for a designated holiday, the employee must be in paid status the work day before and the work day after the designated holiday. In addition to straight-time holiday pay, if the holiday is worked, the employee shall be paid for all hours worked at the overtime rate of time and one-half (1.5). If the holiday is not worked because of a regular day off, or by employer request, employee will be paid holiday pay at the straight time rate. In the event that a holiday falls on an employee's day off, the employee may take the holiday in pay or comp time at straight time, at his/her election.

Rates: Full-Time Employees

Monthly Medical Plan Rates for Eligible Permanent Full-Time Employees (excludes Sworn Fire)

Effective January 1, 2021

Medical Plans	REGION 1 Counties: Alameda, Alpine, Amador, Butte, Calavares, Colusa, Contra Costa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba					
	Monthly Premium Cost			Monthly Employee Contribution		
	Employee Only	Employee + 1	Employee + 2 or more	Employee Only	Employee + 1	Employee + 2 or more
Anthem EPO Del Norte	$935.84	$1,871.68	$2,433.18	$122.20	$244.40	$317.72
Anthem Select HMO	$925.60	$1,851.20	$2,406.56	$111.96	$223.92	$291.10
Anthem Traditional HMO	$1,307.86	$2,615.72	$3,400.44	$494.22	$988.44	$1,284.98
Blue Shield Access+ HMO	$1,170.08	$2,340.16	$3,042.21	$356.44	$712.88	$926.75
Blue Shield Access EPO	$1,170.08	$2,340.16	$3,042.21	$356.44	$712.88	$926.75
Blue Shield Trio	$880.50	$1,761.00	$2,289.30	$66.86	$133.72	$173.84
Health Net SmartCare HMO	$1,120.21	$2,240.42	$2,912.55	$306.57	$613.14	$797.09
Kaiser (CA) HMO	$813.64	$1,627.28	$2,115.46	$0.00	$0.00	$0.00
PERS Choice	$935.84	$1,871.68	$2,433.18	$122.20	$244.40	$317.72
PERS Select	$566.67	$1,133.34	$1,473.34	$0.00	$0.00	$0.00
PERSCare	$1,294.69	$2,589.38	$3,366.19	$481.05	$962.10	$1,250.73
PORAC *(POLICE ONLY)*	$799.00	$1,725.00	$2,199.00	$0.00	$97.72	$83.54
United HealthCare HMO	$941.17	$1,882.34	$2,447.04	$127.53	$255.06	$331.58
Western Health Advantage	$757.02	$1,514.04	$1,968.25	$0.00	$0.00	$0.00

Medical Plans	REGION 2 Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, San Diego, San Luis Obispo, Santa Barbara, Tulare, and Ventura					
	Monthly Premium Cost			Monthly Employee Contribution		
	Employee Only	Employee + 1	Employee + 2 or more	Employee Only	Employee + 1	Employee + 2 or more
Anthem Select HMO	$674.69	$1,349.38	$1,754.19	$0.00	$0.00	$0.00
Anthem Traditional HMO	$1,046.04	$2,092.08	$2,719.70	$232.40	$464.80	$604.24
Blue Shield Access+ HMO	$938.96	$1,877.92	$2,441.30	$125.32	$250.64	$325.84
Blue Shield Trio	$722.56	$1,445.12	$1,878.66	$0.00	$0.00	$0.00
Health Net Salud y Mas	$458.66	$917.32	$1,192.52	$0.00	$0.00	$0.00
Health Net SmartCare HMO	$769.11	$1,538.22	$1,999.69	$0.00	$0.00	$0.00
Kaiser (CA) HMO	$669.77	$1,339.54	$1,741.40	$0.00	$0.00	$0.00
PERS Choice	$783.19	$1,566.38	$2,036.29	$0.00	$0.00	$0.00
PERS Select	$476.92	$953.84	$1,239.99	$0.00	$0.00	$0.00
PERSCare	$1,115.68	$2,231.36	$2,900.77	$302.04	$604.08	$785.31
PORAC *(POLICE ONLY)*	$749.00	$1,499.00	$1,960.00	$0.00	$0.00	$0.00
Sharp	$632.27	$1,264.54	$1,643.90	$0.00	$0.00	$0.00
United HealthCare HMO	$723.84	$1,447.68	$1,881.98	$0.00	$0.00	$0.00

IMPORTANT NOTE - You must verify the plan is available in your home or work zip code area.

Rates: Full-Time Employees (continued)

Monthly Medical Plan Rates for Eligible Permanent Full-Time Employees (excludes Sworn Fire)

Effective January 1, 2021

Medical Plans	REGION 3 Los Angeles, Riverside, San Bernardino					
	Monthly Premium Cost			Monthly Employee Contribution		
	Employee Only	Employee + 1	Employee + 2 or more	Employee Only	Employee + 1	Employee + 2 or more
Anthem Select HMO	$639.10	$1,278.20	$1,661.66	$0.00	$0.00	$0.00
Anthem Traditional HMO	$984.21	$1,968.42	$2,558.95	$170.57	$341.14	$443.49
Blue Shield Access+ HMO	$834.88	$1,669.76	$2,170.69	$21.24	$42.48	$55.23
Blue Shield Trio	$660.49	$1,320.98	$1,717.27	$0.00	$0.00	$0.00
Health Net Salud y Mas	$412.88	$825.76	$1,073.49	$0.00	$0.00	$0.00
Health Net SmartCare HMO	$691.48	$1,382.96	$1,797.85	$0.00	$0.00	$0.00
Kaiser (CA) HMO	$669.84	$1,339.69	$1,741.60	$0.00	$0.00	$0.00
PERS Choice	$761.23	$1,522.46	$1,979.20	$0.00	$0.00	$0.00
PERS Select	$459.94	$919.88	$1,195.84	$0.00	$0.00	$0.00
PERSCare	$1,036.07	$2,072.14	$2,693.78	$222.43	$444.86	$578.32
PORAC *(POLICE ONLY)*	$725.00	$1,450.00	$1,894.00	$0.00	$0.00	$0.00
United HealthCare HMO	$720.89	$1,441.78	$1,874.31	$0.00	$0.00	$0.00

IMPORTANT NOTE - You must verify the plan is available in your home or work zip code area.

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Rates: Full-Time Employees (continued)

Monthly Medical Plan Rates for Eligible Permanent Full-Time Employees (excludes Sworn Fire)

Effective January 1, 2021

Medical Plans	REGION - OUT OF STATE					
	Monthly Premium Cost			Monthly Employee Contribution		
	Employee Only	Employee + 1	Employee + 2 or more	Employee Only	Employee + 1	Employee + 2 or more
PERS Choice	$760.17	$1,520.34	$1,976.44	$0.00	$0.00	$0.00
PERSCare	$1,008.08	$2,016.16	$2,621.01	$194.44	$388.88	$505.55
PORAC *(POLICE ONLY)*	$899.00	$1,850.00	$2,223.00	$85.36	$222.72	$107.54

IMPORTANT NOTE - You must verify the plan is available in your home or work zip code area.

Introduction

As City of Oakland employees, you and your family are entitled to a number of benefits. This benefits guide contains information on all of the benefits you are entitled to as an employee of the City of Oakland.

In order to activate your benefits, complete and submit the following:

- CalPERS Beneficiary Designation Form
- City of Oakland Employee Benefits Record (EBR)

Optional Benefit Forms

- Flexible Spending Plan Enrollment form
- Pre-designation of Personal Physician

You have 60 days from the date of your initial appointment to enroll or decline coverage for yourself and eligible family members. Benefits will begin on the 1st of the month after you submit your paperwork and appropriate documentation to the Human Resources Management and Risk Benefits Division. If you do not enroll during the initial 60 days and have not experienced a qualifying life event, your enrollment will be subject to a 90-day waiting period or the following Open Enrollment period, whichever comes first.

For participation in the deferred compensation plan, your paperwork needs to be in our office by the 15th of the month; deductions will begin with the first pay period of the following month. For example, if you submit your paperwork by January 15th, deductions will begin with the February's first pay period.

Any questions you may have regarding the enclosed information can be referred to the corresponding representative listed in your "Benefits Telephone Directory" found at the beginning of this guide.

Benefit Choices

The City recognizes that your benefits are an important part of the reason you choose to work here. The City provides high quality benefits at a reasonable cost to you. You can choose between different medical plans to meet your individual and family needs. Since you have some choices to make, it is important to understand the various programs. That is why this Handbook is being provided for you. There are also individual brochures for each of the benefit plans available in the Human Resources department. Benefits provided by the City for eligible employees include a choice of CalPERS medical plans, dental and group life insurance. Dental and group life insurance plans for sworn police employees are administered by OPOA. Optional benefits include a vision plan and voluntary life insurance coverage, administered by OPOA.

Eligibility

Employees

Employees may opt out of coverage with proof of other group coverage.

Dependents

When enrolling dependents, appropriate documentation and/or proof of dependent status is required by the City and will be requested by Human Resources.

Accepted forms of proof include Marriage and Birth Certificates, Tax Returns, Local City Government or State Issued Declaration of Domestic Partnership, Adoption Certificate or Proof of Legal Guardianship.

For purposes of medical plan coverage, the following dependents are eligible:

- A spouse who is not currently enrolled as an employee in a Public Employees Retirement System (PERS)-administered medical plan
- A registered domestic partner
- Certified disabled child age 26 or older
- Child (up to age 26) for whom you have a parent-child relationship (restrictions apply)

Enrollment

Open Enrollment

Once a year, usually during the fall, the City of Oakland holds an Open Enrollment period. During this time, you may change to a different medical plan, enroll in the dental plan and the vision plan. You may also add or delete dependents to your medical, dental or vision plan.

Supporting documentation will be required by Human Resources to add or delete new dependents.

Enrollment Instructions

When you are hired, you will receive this Employee Benefits Guide describing your different benefits. Additional brochures are available at the City of Oakland. Your coverage will start on the first of the month following the date your enrollment paperwork is received.

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

1. Review the section of this Guide on medical plans to determine which medical plan suits your health and financial needs.
2. Review additional voluntary benefits offered by the City to determine whether they meet your needs.

The following forms must be provided in order to commence your benefits (please attach required copies of documents for dependents):

- Employee Benefits Record (EBR) form
- CalPERS Beneficiary Designation form

Online enrollment is required for Parking and Transit Programs, and the Guaranteed Ride Home.

Please submit your forms and required documents to the Benefits Unit, benefitsadmin@oaklandca.gov, 150 Frank Ogawa Plaza, 2nd Floor front counter or you can fax your forms to 510.238.6560.

All benefits information can be found on the City of Oakland's Benefits web page: www.oaklandca.gov/benefits or at 150 Frank H. Ogawa Plaza, 2nd Floor (Human Resources Front Counter) Oakland, CA 94612.

Change in Beneficiaries

Certain events in your life such as marriage, divorce, or a death in the family can affect who you name as your designated beneficiary for certain benefits. You may change your beneficiary(ies) at any time. If you wish to do so, you can obtain most beneficiary forms from Human Resources.

You can designate a beneficiary for:

- Deferred Compensation
- Life Insurance
- Retirement - CalPERS

Changes in Coverage

Qualifying Events

You may experience certain events during the plan year that would allow you to change you or your dependent's medical coverage. If any of the following events occur, you must change your benefit coverage within 60 days of the event:

- Change in your legal marital or domestic partner status, including marriage, death of your spouse/domestic partner, divorce, legal separation or annulment.
- Change in the number of your dependents, including birth, adoption, placement for adoption or death of your dependent.
- Change in your employment status, including termination or commencement of employment of you, your spouse, your domestic partner or your dependent.
- Change in work schedule for you or your spouse/domestic partner, including an increase or decrease in the number of hours of employment, a switch between full-time and part-time status, a strike, lockout or commencement or return from an unpaid leave of absence.
- Your dependent satisfies or no longer meets the eligibility requirements for dependents.
- A change in the place of residence or worksite of you or your spouse/domestic partner (this move must affect your coverage options).
- You, your spouse/domestic partner or your dependents lose COBRA coverage.
- You, your spouse/domestic partner or your dependents enroll for Medicare or Medicaid or lose coverage under Medicare or Medicaid.
- A significant change in benefit or cost of coverage for you or your spouse/domestic partner.
- Your spouse/domestic partner employer provides the opportunity to enroll or change benefits during an open enrollment period.

Special Enrollment Rights as Provided by HIPAA

- You initially declined coverage under the plan because you had coverage under another plan and subsequently incurred a loss of coverage under the other plan.
- Occurrence of certain events such as birth, adoption, placement for adoption or marriage.

2021 Summary of Benefits and Coverage Notice

Choosing your health plan is an important decision. To assist you with this process, each health plan available through the California Public Employees' Retirement System has produced a Summary of Benefits and Coverage (SBC). In addition, the federal government has compiled a glossary of common health insurance terms. Together, these documents provide important information to help you better understand your health benefit coverage and more easily compare health plan options.

To view the SBCs and glossary online, visit www.calpers.ca.gov* under the Plans and Rates section (subsection Health Plans), or visit any of the health plan websites below. To request a free paper copy of the SBC and glossary, please contact each health plan directly.

Anthem Blue Cross HMO & EPO
855.839.4524
www.anthem.com/ca/calpershmo

Blue Shield of California
800.334.5847
www.blueshieldca.com/calpers

California Association of Highway Patrolmen**
800.734.2247
www.thecalhp.org

California Correctional Peace Officers Association**
800.257.6213
www.ccpoabtf.org

Health Net of California
888.926.4921
www.healthnet.com/calpers

Kaiser Permanente
800.464.4000
www.kp.org/calpers

Peace Officers Research Association of California**
800.288.6928
http://ibt.porac.org

PERS Select, PERS Choice, and PERSCare
877.737.7776
www.anthem.com/ca/calpers

Sharp Health Plan
855.995.5004
www.sharphealthplan.com/calpers

UnitedHealthcare
877.359.3714
www.uhc.com/calpers

Western Health Advantage
888.942.7377
www.westernhealth.com/calpers

* **https:**//www.calpers.ca.gov/page/active-members/health-benefits/plans-and-rates

** To enroll in these health plans, you must belong to the specific employee association and pay applicable dues.

Medical – CalPERS

The City of Oakland offers several different medical plan options; Health Maintenance Organizations (HMO) or Preferred Provider Organizations (PPO) for all full-time and permanent part-time employees and their eligible dependents.

Health Maintenance Organizations (HMOs)

HMOs allow you to receive comprehensive coverage at set prices, called copays.

- **Doctors/Other Medical Care Providers.** You can only use doctors, hospitals, and pharmacies that participate in the HMO network. Doctors who participate in the HMO network are called in- network providers. There is no coverage if you go to out-of-network providers, except for emergency services.
- **Annual Deductible.** You don't need to pay an annual deductible before the plan begins to pay for a portion of covered medical services.
- **Copays.** When you receive medical care, you pay a set dollar amount called a copay.
- **Annual Out-of-Pocket Maximum.** The HMO plans include an annual out-of-pocket maximum. This is the maximum amount you must pay out of your own pocket for copays during the plan year. Once you reach the out-of-pocket maximum, the plan pays 100% of covered charges for the remainder of the plan year.

Preferred Provider Organization (PPO)

The PPO plan allows you to use any provider you choose.

- **Doctors/Health Care Providers.** You can choose any doctor you want, and you can go to any hospital or pharmacy. However, you'll pay less when you use a provider or facility that participates in-network.
- **Preventive Care.** Preventive care is 100% covered when you use in-network providers. Visit healthcare.gov/preventive-care-benefits/ for a complete list of preventive care benefits required to be covered at 100% per the Affordable Care Act.
- **Annual Deductible.** You generally pay an annual deductible before the plan begins to pay for a portion of covered medical services.
- **Paying for Care. When you receive medical care, there are two ways you pay for services:**
  - **Copays.** When you go to an in-network doctor for an office visit, go to the emergency room, or pick up a prescription, you pay a set dollar amount called a copay. (You may need to pay the annual deductible first before the copay applies.)
  - **Coinsurance.** When you receive any other medical services, you pay a percentage of the cost of the service and the plan pays the remaining percentage. This is called coinsurance. (You will need to pay the annual deductible first before coinsurance applies.)
- **Annual Out-of-Pocket Maximum.** The PPO includes an out-of-pocket maximum. This is the maximum amount you must pay out of your own pocket (under the applicable coinsurance percentage) after meeting the deductible. Once you reach the out-of-pocket maximum, the plan pays 100% of in- network charges for the remainder of the plan year. Please note that your out-of-pocket maximum will be lower when you use in-network providers.

2021 CalPERS – EPO & HMO Basic Plans

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	Anthem Blue Cross EPO Select HMO Traditional HMO	Blue Shield Access+ HMO & Access+ EPO Trio HMO	Health Net Salud y Más & SmartCare	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	Western Health Advantage HMO
Calendar Year Deductible							
• Individual	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maximum Calendar Year Copay or Coinsurance *(excluding pharmacy)*							
• Individual	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)
• Family	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)
Hospital *(including Mental Health and Substance Abuse)*							
• Deductible *(per admission)*	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient Facility/ Surgery Services	No Charge	No Charge	No Charge	$15	No Charge	No Charge	No Charge
Emergency Services							
• Emergency Room Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Emergency *(copay waived if admitted as an inpatient or for observation as an outpatient)*	$50	$50	$50	$50	$50	$50	$50
• Non-Emergency *(copay waived if admitted as an inpatient or for observation as an outpatient)*	$50	$50	$50	$50	$50	$50	$50

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2021 CalPERS – EPO & HMO Basic Plans (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	Anthem Blue Cross EPO Select HMO Traditional HMO	Blue Shield Access+ HMO & Access+ EPO Trio HMO	Health Net Salud y Más & SmartCare	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	Western Health Advantage HMO
Physician Services *(including Mental Health and Substance Abuse)*							
• Office Visits *(copay for each service provided)*	$15	$15	$15	$15	$15	$15	$15
• Inpatient Visits	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient Visits	$15	$15	$15	$15	$15	$15	$15
• Urgent Care Visits	$15	$15	$15	$15	$15	$15	$15
• Preventive Services	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Surgery/Anesthesia	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostic X-Ray/Lab							
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Prescription Drugs							
• Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Retail Pharmacy *(not to exceed 30-day supply)*	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $5 Brand: $20	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $5 Brand Formulary: $20 Non-Formulary: $50
• Retail Preferred Pharmacy Maintenance Medications	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	N/A	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100
• Mail Order Pharmacy Program *(not to exceed 90-day supply for maintenance drugs)*	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand: $40 (31-100 day supply	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100
• Mail order maximum copayment per person per calendar year	$1,000	$1,000	$1,000	N/A	$1,000	$1,000	$1,000

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2021 CalPERS – EPO & HMO Basic Plans (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	Anthem Blue Cross EPO Select HMO Traditional HMO	Blue Shield Access+ HMO & Access+ EPO Trio HMO	Health Net Salud y Más & SmartCare	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	Western Health Advantage HMO
Durable Medical Equipment							
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Infertility Testing/Treatment							
	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges
Occupational /Physical /Speech Therapy							
• Inpatient *(hospital or skilled nursing facility)*	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient *(office and home visits)*	$15	$15	$15	$15	$15	$15	$15
Diabetes Services							
• Glucose monitors	Coverage Varies	No Charge	Coverage Varies	No Charge	Coverage Varies	Coverage Varies	Coverage Varies
• Self-management training	$15	$15	$15	$15	$15	$15	$15
Acupuncture							
	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)
Chiropractic							
	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)

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2021 CalPERS – PPO Basic Plans

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Calendar Year Deductible								
• Individual	$1,000 [1,3]		$500 [3]		$500 [3]		$300	$600
• Family	$2,000 [1,3]		$1,000 [3]		$1,000 [3]		$900	$1,800
Maximum Calendar Year Copay or Coinsurance *(excluding pharmacy)*								
• Individual	$3,000 (coinsurance)	Unlimited	$3,000 (coinsurance)	Unlimited	$2,000 (coinsurance)	Unlimited	$2,000	Unlimited
• Family	$6,000 (coinsurance)	Unlimited	$6,000 (coinsurance)	Unlimited	$4,000 (coinsurance)	Unlimited	$4,000	Unlimited
Hospital *(including Mental Health and Substance Abuse)*								
• Deductible *(per admission)*	N/A		N/A		$250		N/A	
• Inpatient	20% [2]	40% [4]	20%	40% [4]	10%	40% [4]	20%	20% [4]
• Outpatient Facility/ Surgery Services	20%	40% [4]	20%	40% [4]	10%	40% [4]	20%	20% [4]
Emergency Services								
• Emergency Room Deductible	$50 (applies to hospital emergency room facility charge only)		$50 (applies to hospital emergency room charges only)		$50 (applies to hospital emergency room charges only)		N/A	
• Emergency	20% (applies to other services such as physician, x-ray, lab, etc.)		20% (applies to other services such as physician, x-ray, lab, etc.)		10% (applies to other services such as physician, x-ray, lab, etc.)		20%	
• Non-Emergency	20%	40%	20%	40%	10%	40%	50% (for non-emergency services provided by hospital emergency room)	
	(payment for physician charges only; emergency room facility charge is not covered)		(payment for physician charges only; emergency room facility charge is not covered)		(payment for physician charges only; emergency room facility charge is not covered)			
Physician Services *(including Mental Health and Substance Abuse)*								

1 **Incentives available to reduce individual deductible (max. $500) or family deductible (max. $1,000) include:** getting a biometric screening ($100 credit); receiving a flu shot ($100 credit); getting a non-smoking certification ($100 credit); getting a virtual second opinion ($100 credit); and getting a condition care certification ($100 credit).

2 Coinsurance waived for deliveries if enrolled in Future Moms Program.

3 Deductible is transferable between PERS Select, PERS Choice, and PERS Care.

4 Of the allowable amount as defined in the EOC.

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2021 CalPERS – PPO Basic Plans (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
• Office Visits *(copay for each service provided)*	$35 [1]	40% [3]	$20 [2]	40% [3]	$20 [2]	40% [3]	$10/$35 [2]	20% [3]
• Inpatient Visits	20%	40% [3]	20%	40% [3]	10%	40% [3]	20%	20% [3]
• Outpatient Visits	$35	40% [3]	$20	40% [3]	$20	40% [3]	20%	20% [3]
• Urgent Care Visits	$35	40% [3]	$35	40% [3]	$35	40% [3]	$35	20% [3]
• Preventive Services	No Charge	40% [3]	No Charge	40% [3]	No Charge	40% [3]	No Charge	
• Surgery/Anesthesia	20%	40% [3]	20%	40% [3]	10%	40% [3]	20%	20% [3]
Diagnostic X-Ray/Lab								
	20%	40% [3]	20%	40% [3]	10%	40% [3]	20%	20% [3]
Prescription Drugs								
• Deductible	N/A		N/A		N/A		N/A	
• Retail Pharmacy *(not to exceed 30-day supply)*	Generic: $5 Formulary: $20 Non-Formulary: $50		Generic: $5 Formulary: $20 Non-Formulary: $50		Generic: $5 Formulary: $20 Non-Formulary: $50		Generic: $10 Brand Formulary: $25 Non-Formulary: $45 Compound: $45	
• Retail Preferred Pharmacy Maintenance Medications	Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100		N/A	
• Mail Order Pharmacy Program *(not to exceed 90-day supply for maintenance drugs)*	Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $20 Brand Formulary: $40 Non-Formulary: $75	N/A
• Mail order maximum copayment per person per calendar year	$1,000		$1,000		$1,000		N/A	
Durable Medical Equipment								

1 Reduced to $10 if enrolled with personal doctor.

2 $35 for specialist visit.

3 Of the allowable amount as defined in the EOC

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2021 CalPERS – PPO Basic Plans (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
	20%	40% [2]	20%	40% [2]	10%	40% [2]	20%	20% [2]
	(pre-certification required for equipment)		(pre-certification required for equipment)		(pre-certification required for equipment $1,000 or more)			
Infertility Testing/Treatment								
	50%		50%		50%		50%	50% [2]
Occupational / Physical / Speech Therapy								
• Inpatient *(hospital or skilled nursing facility)*	No Charge		No Charge		No Charge		$20 occupational/speech; no charge	20% [2]
• Outpatient *(office and home visits)*	20%	40%; Occupational therapy: 20%	20%	40%; Occupational therapy: 20%	10%	40%; Occupational therapy: 10%	$20	20% [2]
	(Pre-certification required for more than 24 visits)		(Pre-certification required for more than 24 visits)		(Pre-certification required for more than 24 visits)			
Diabetes Services								
• Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies	
• Self-management training	$20 [1]	40% [2]	$20 [1]	40% [2]	$20 [1]	40% [2]	$20	60% [2]
Acupuncture								
	$15/visit	40% [2]	$15/visit	40% [2]	$15/visit	40% [2]	$15 (10% for all other services)	20% [2]
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)			
Chiropractic								
	$15/visit	40% [2]	$15/visit	40% [2]	$15/visit	40% [2]	$15/up to 20 visits	20% [2]
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)			

1 35 for specialist visit.

2 Of the allowable amount as defined in the EOC

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Other Core Benefits

Dental

Dental benefits are administered by Delta Dental through OPOA. Please contact Renee Hassna at 510.834.9670 or at renee@opoa.org for more information.

Vision

Vision benefits are administered through OPOA. Please contact Renee Hassna at 510.834.9670 or renee@opoa.org for more information.

Group Life and AD&D/Voluntary Life/Disability

Please contact OPOA for more information on your Life/AD&D and Disability benefits.

Employee Assistance Program (EAP)

Please contact OPOA for more information on your EAP benefit.

Other Benefits

Flexible Spending Accounts (FSA)

The City offers a tax-free benefit plan that provides you with ways to save up to thousands of dollars per year by offering the option to pay for certain types of expenses with pre-tax payroll deductions. If you choose to participate, you will reduce your taxable income.

What is the maximum I can elect?

For 2021, the maximum contribution amount is $2,750.

How do I use the Medical FSA?

The Medical Expense FSA allows you to set aside tax-free dollars that will reimburse you for qualifying medical, dental and vision expenses incurred during the plan year. Incurred means the service must be performed during the plan year. Qualified expenses include most medically necessary out-of-pocket medical, dental, and vision related expenses. Insurance premiums of any kind including, Medicare, individual health insurance, long-term care, warranties, or membership fees that are not directly related to care are not eligible for reimbursement through the Medical FSA.

Can I be reimbursed through FSA for medical expenses incurred by my family members?

Yes! You may save taxes on all qualified medical expenses incurred by you, your spouse, and your dependent children. You may NOT be reimbursed for expenses incurred by a domestic partner unless your domestic partner is your federal tax dependent.

You plan allows reimbursement for qualified expenses that you incur for an eligible adult child up to the age 26.

How do I access my benefits?

Accessing your benefits couldn't be easier, just swipe your Navia Benefit Card to pay for eligible health care expenses. Funds come directly out of your Health FSA and are paid to the provider. Some swipes require us to verify the expense, so hang on to your receipts. If we need to see it, we will send you an email or notification via our smartphone app.

You can also submit Health Care FSA and Day Care FSA claims online, through our smartphone app for Android and iPhone, email, fax or mail. Claims are processed within a few days and reimbursements are issued according to your employer's reimbursement schedule. Be sure to include documentation that clearly shows the date, type and cost of the service.

Submitting claims is easier than ever using FlexConnect

The FlexConnect feature connects your FSA to your insurance plans and seamlessly creates a claim with proper documentation direct from your insurance carrier. All you have to do is click "reimburse me" and the claim is expedited for payment. Sign up for FlexConnect today.

Get more with the MyNavia mobile app

The MyNavia app is free to download on both iPhone and Android. You can manage your benefits and view important details right from the convenience of your phone.

The medical FSA account is pre-funded, meaning your entire annual election amount is available for reimbursement at any time during the plan year, regardless of the amount you have contributed from your paycheck.

Election and Claim Filing Period

Open Enrollment period is a great time to look at your benefits and estimate your out-of-pocket expenses. Be sure to only elect an amount that you know you will use during your plan year. At the end of the plan year you will have a claim fling period to turn in any leftover claims for your benefits. Money left in the plan after the end of the claim filing period and 2 ½ month Grace Period is subject to the Use-or-Lose rule and cannot be refunded to you.

Grace Period

Your plan also has a special 2 ½ month Grace Period after the end of the plan year. This feature gives you an additional 2 ½ months to incur expenses against your Health Care and Day Care arrangements. All expenses incurred during the grace period will automatically deduct out of the prior year's arrangement, and any remaining balance will then be applied to the current plan year.

Other Benefits (continued)

Navia Benefits Card

Rather than filing a claim and waiting for reimbursement, you can use the debit card to pay your provider directly for qualified health care expenses. The card is accepted at participating merchants using the Inventory Information Approval System (IIAS) and at medical care merchants using the Master-Card® system. Be sure to hang on to your receipts in case we need to see them to verify the expense eligibility. If we need to see a receipt, you will notice an alert on your mobile app and we will send you an email reminder.

Accessing Your Benefits

Navia wants to make accessing your benefits as simple and efficient as possible.

- **Online Account Access:** Order additional debit cards, update bank and address information and see up to date details of your benefits.
- **Online Claims Submission:** Upload your documentation, complete the online wizard, and voila! A reimbursement will be on its way within a few days!
- **Mobile App:** MyNavia allows you to simply snap a photo and submit for reimbursement direct from your mobile device.
- **Flexconnect:** Sync your various medical, dental and vision benefits with your FSA plan for a quick and easy reimbursement. No need to submit documentation, we'll get it from the insurance carrier.

How do I enroll in the FSA plan?

You will make your Flexible Spending Account election during Open Enrollment each year. You can obtain copies of enrollment information and instructions from the City.

The following is a sample of permitted expenses:

- Acupuncture
- Allergy treatments
- Chiropractic
- Contact lenses & supplies
- Dental (non-cosmetic)
- Doctor office visits & exams
- Glasses (prescription)
- Hearing aids
- Insulin & insulin supplies
- Insurance copays and deductibles
- Laboratory fees
- Therapy
- Psychiatric care
- Prescriptions (medically necessary)

Transit/Parking Reimbursement Program

Commuting to work each day can be expensive. The commuter benefit program offered by the City of Oakland through Navia will help you save money on your commuting costs. The GoNavia Program allows you to pay for work related transportation costs with pre-tax dollars.

What is the maximum monthly pre-tax benefit permitted allowed?

- The maximum amount that the City of Oakland will deduct from your pay each month is equal to the maximum tax-free limit authorized by the IRS for that year.
- For 2021, the pre-tax parking limit is $270 per month.
- For 2021, the pre-tax transit and van pooling limit is $270 per month.

The City of Oakland is committed to preserving the environment and wants to encourage employees to contribute to these efforts by taking public transportation whenever practical. Together we can save money and the environment at the same time!

For information about how to enroll in the Commuter Benefit online, please visit the HR department for an online instruction guide.

Dependent Care Assistance Program

This option enables you to decrease your tax liability while setting aside funds to pay for child or elder care expenses. After expenses are incurred, you can submit receipts for reimbursement from a flexible spending account. The maximum annual contribution is $5,000 for a family or $2,500 each for you and your spouse.

Other Benefits (continued)

Deferred Compensation

Full-time and permanent employees can elect to participant in the voluntary retirement plan, a 457(b), this reduces the employee's taxable income while providing savings for retirement. An employee can contribute as little as $10 per pay period up to the maximum IRS allowable limit per plan year. The City does not contribute or match the employee's contribution.

Our 457 plan also allows you to add Roth assets now for tax-free income later. Is the Roth right for you? It's a trade-off. You don't get an up-front tax benefit for Roth contributions like you do with pre-tax contributions. And converting pre-tax assets to Roth requires that you pay up-front taxes. But in exchange, Roth assets can provide tax-free income in retirement.

Retirement

In lieu of Social Security, the City of Oakland pays into the California Public Employees' Retirement System (PERS). All sworn OPOA members must make retirement contributions through bi-weekly payroll deductions.

The current retirement formulas for represented OPOA members are:

- **Tier One: Safety 3% at 50 Retirement Plan –** Unit Members hired prior to July 1, 2011.
  - **3% at 50 Retirement Formula**
  - **Employee Contribution.** Each unit member shall pay a contribution of nine percent (9%).
  - **Final Compensation Based on 12 Month Period.** Final compensation will be based on the highest twelve (12) consecutive month period of compensation earnable.
- **Tier Two: Safety 3% @ 55 Retirement Plan** - Unit Members hired on or after July 1, 2011 but before January 1, 2013 and Classic Unit Members as determined by CalPERS. This also applies to unit members hired on or after January 1, 2013 who are qualified for pension reciprocity as stated in Government Code Section 7522.02© and related CalPERS reciprocity.
  - **3% @ 55 Retirement Formula**
  - **Employee Contribution.** Each unit member shall pay a contribution of nine percent (9%).
  - **Final Compensation Based on Three Year Average.** Final compensation is based on highest three (3) consecutive year period of compensation earnable, as specified in Government Code 20037.
- **Tier Three: Safety 2.7% at 57 Retirement Plan –** Unit Members hired on or after January 1, 2013 and who do not qualify for pension reciprocity as stated in Government Code Section 7522.02 (c).
  - **2.7% at 57 Retirement Formula**
  - **Employee Contribution.** Each unit member shall pay fifty percent (50%) of normal cost.
  - **Final Compensation Based on Three Year Average.** Final compensation is based on the highest average annual pensionable compensation earned during the thirty-six (36) consecutive months of service.
- **Employee Contribution to Employer Share.** Effective January 1, 2013, all represented members shall pay the full, normal retirement contribution of nine percent (9%). Effective January 1, 2016, Tier One and Tier Two members shall pay two percent (2%) of the employer's share of the CalPERS pension cost on a pre-tax basis pursuant to section 414(h)(2) of the Internal Revenue Code and will be attributed to the employee's CalPERS account to the extent permissible by the California Public Employee Retirement Law. An additional one percent (1%) shall be effective January 1, 2017.
- **Employees interested in learning more about their retirement may contact CalPERS directly at 888.225.7377 or visit the CalPERS website at calpers.ca.gov. Alternatively, employees may also contact the City of Oakland's Retirement Office at 510.238.6479, weekdays from 8:30 AM to 5:00 PM.**

Unemployment Insurance

This benefit, which is offered through the State of California's Employment Development Department (EDD), allows you to receive funds in the event you become unemployed.

Other Benefits (continued)

Guaranteed Ride Home (GRH)

The Alameda County Guaranteed Ride Home (GRH) Program provides a free ride home from work for employees who do not drive alone to work when unexpected circumstances arise. The GRH program is free for employees who work in Alameda County and use sustainable forms of transportation including walking, biking, taking transit or ridesharing. When a registered employee uses a sustainable mode to travel to work and experiences a personal or family emergency while at work, they can take a taxi or rental car ride home and be reimbursed for the cost of the ride.

This program allows commuters to feel comfortable taking the bus, train or ferry, carpooling, vanpooling, walking, or bicycling to work, knowing that they will have a ride home in case of an emergency.

All permanent part-time or full-time employees 18 years of age or older who work in Alameda County are eligible to participate.

When can I take a Guaranteed ride home?

Registered employees may request reimbursement for eligible expenses if they take a trip home in a qualified emergency situation and have used an alternative mode that day.

The following circumstances are considered qualifying emergency situations in the GRH program and must occur on the date of the GRH trip:

- Participant or an immediate family member suffers an illness, injury, or severe crisis.
- Participant is asked by supervisor to work unscheduled overtime. Supervisor verification will be required as part of reimbursement request.
- Participant ridesharing vehicle breaks down or the driver has to leave early.
- Participant has a break-in, flood, or fire at residence.
- Participant's commute bicycle breaks down on the way to or from work and cannot be repaired at participant's work site.

In addition, participants must have used an alternative mode on the day they take the ride for which they will seek reimbursement through the GRH program. Eligible alternative commute modes include:

- **Public transportation including:** BART, AC Transit, ACE, Wheels, Union City Transit, ferry (WETA) and Amtrak
- Employer-provided shuttle or van service
- Carpool or Vanpool
- Bicycle
- Walk

Enrollment can be completed online at grh.alamedactc.org. For questions, please contact the City of Oakland at 510.238.2248.

Important Notices

Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 510.238.7446 for more information.

Patient Protections

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

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

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

Networks/Claims/Appeals

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

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

Important Notices (continued)

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than their gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or,
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- The parent-employee dies;
- The parent-employee's employment ends for any reason other than their gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or,
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. The employer must notify the Plan Administrator of the following Qualifying Events:

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

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

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

NOTICE AND ELECTION PROCEDURES

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

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

ELECTION AND ELECTION PERIOD

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

Important Notices (continued)

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. (See Notice and Election Procedures.)

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

Important Notices (continued)

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

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

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

IF YOU HAVE QUESTIONS

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

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

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

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

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

Important Notices (continued)

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

For information about Special Enrollment Rights, please contact:

Denise Carter
Human Resources
510.238.7446

Medicare Part D – Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Oakland 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.**
- **CalPERS has determined that the prescription drug coverage offered by City of Oakland Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

Important Notices (continued)

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 Oakland coverage will not be affected. If you keep this coverage and elect Medicare, the City of Oakland coverage will coordinate with Part D coverage.

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

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

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

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

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

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

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

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

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 / Sender:	City of Oakland
Contact:	Denise Carter, Human Resources
Address:	150 Frank Ogawa Plaza, 3rd Floor Oakland, CA 94612
Phone:	510.238.7446

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

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

Important Notices (continued)

Important Notice Regarding Wellness Information

The City of Oakland's Wellness Program is a voluntary program available to all employees and is subject to federal law including the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act.

If you choose to participate, you may be asked to complete a voluntary health risk assessment that asks questions about your health-related activities and behaviors and whether you have or had certain medical conditions. You may also be asked to complete a voluntary biometric screening which includes receiving screening results for your blood glucose, total cholesterol, blood pressure, and height and weight to determine Body Mass Index (BMI).

The information gathered from your health risk assessment and/or biometric screening will be used to provide you with information to help you understand your current health, potential risks, and may also be used to offer you services through the wellness program. You are also encouraged to share your results or concerns with your own doctor.

The law requires us to maintain the privacy and security of your personally identifiable health information. Although the wellness program and City of Oakland may use aggregate, non-employee specific information to design a program to address health risks in the workplace, your personal identifiable information will never be disclosed publicly or to your employer. Medical information that personally identifies you in connection with the wellness program will not be disclosed to your supervisors or managers and will never be used to make decisions regarding your employment. Anyone (e.g., a registered nurse, a doctor, health coach, etc.) who receives information about you for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

All medical information obtained through the wellness program will be maintained in a secure and confidential manner.

If you have any questions or concerns, please contact Lana Chan at LChan2@oaklandca.gov and Erika Turner at ETurner@oaklandca.gov.

Important Notices (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

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

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.83% (for 2021) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

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

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

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

PART B: EXCHANGE APPLICATION INFORMATION

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

3. Employer name City of Oakland	**4. Employer Identification Number (EIN)** 94-6000384	
5. Employer address 150 Frank Ogawa Plaza, 3rd Floor	**6. Employer phone number** 510.238.4749	
7. City Oakland	**8. State** CA	**9. ZIP code** 94612
10. Who can we contact about employee health coverage at this job? Denise Carter, Human Resources		
11. Phone number (if different from above) 510.238.7446	**12. Email address** dcarter@oakland.com	

Important Notices (continued)

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility.

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

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

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

CALIFORNIA – Medicaid
Website:
www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 916.440.5676

COLORADO – Health First Colorado
Colorado's Medicaid Program & Child Health Plan Plus (CHIP+)
Healthy First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 800.221.3943
TTY: Colorado relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 800.359.1991
TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 855.692.6442

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

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

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877.438.4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 800.457.4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800.338.8366
Hawki Website: http://dhs.iowa.gov/Hawki
Phone: 800.257.8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm
Phone: 800.792.4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 855.459.6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 877.524.4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 888.342.6207 (Medicaid hotline) or
855.618.5488 (LaHIPP)

Important Notices (continued)

MAINE – Medicaid
Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800.442.6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800.977.6740 | TTY: Maine relay 711

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

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 800.657.3739

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

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

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

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

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

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

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

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

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

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

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

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 800.692.7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855.697.4347, or 401.462.0311 (Direct RIte Share Line)

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

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

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

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

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

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/hipp/
Medicaid Phone: 800.432.5924
CHIP Phone: 855.242.8282

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

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

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800.362.3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800.251.1269

To see if any other states have added a premium assistance program since July 31, 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
866.444.EBSA (3272)

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

Forms

Benefits Enrollment Forms

The following forms are required:

- Employee Benefits Record form
- CalPERS Beneficiary Designation form

Optional Benefit Forms:

- Flexible Benefit Spending Plan Enrollment form (MCAP & DCAP)
- Cafeteria Plan Election Form (Medical Waiver)
- Predesignation of Personal Physician
- Notice of Personal Chiropractor or Personal Acupuncturist

Where to Submit Your Benefit Enrollment Forms and Required Documentation

Please fax or submit your benefit enrollment forms and required documentation to the Benefits Unit.

FAX

Fax your completed forms to:

510.238.6560

Benefits Unit

BenefitsAdmin@oaklandca.gov

CITY OF OAKLAND EMPLOYEE BENEFITS RECORD FORM

You must submit a completed enrollment form and any required documentation to the DHRM Recruitment, Classification & Benefits Division within 60 days of your initial benefits eligibility date or qualified life event.

APPLICATION TYPE

☐ New Hire ☐ Rehire / Reinstatement ☐ Birth / Adoption ☐ Marriage / New Domestic Partnership / Divorce ☐ Open Enrollment

☐ Loss of Coverage ☐ Other-Please explain: _____

YOUR PERSONAL INFORMATION

Last Name	First Name	Middle Initial

Street Address	Apt. #	City	State	Zip

Employee ID#	Birth Date	Phone Number	Gender
			☐ Male ☐ Female

EMPLOYMENT INFORMATION

Department Name	Job Class	Rep Unit	FT	PPT	Sworn
			☐	☐	☐

CHOOSE YOUR HEALTH PLAN

You must live in a covered service area to enroll in these plans. Please refer to the CalPERS Health Benefit Summary to confirm service areas or visit http://www.calpers.ca.gov.

☐ Kaiser
☐ Anthem HMO Select
☐ Anthem HMO Traditional
☐ Health Net SmartCare
☐ Blue Shield Access
☐ Blue Shield Trio
☐ Western Health Advantage
☐ United Healthcare
☐ PERS Choice PPO*
☐ PERS Select PPO*
☐ PERSCare PPO*
☐ PORAC (Sworn Police only)
☐ Waive Medical Coverage (OPOA are not eligible)

*Administered by Anthem BlueCross

CHOOSE YOUR DENTAL PLAN NON-SWORN ONLY*

☐ Delta Dental PPO*
☐ DeltaCare USA HMO*
☐ Sworn Police OPOA Dental
☐ IAFF Sworn Fire (Indemnity Dental)
☐ Waive Dental Coverage

CHOOSE YOUR VISION PLAN NON-SWORN ONLY

☐ Vision Service Plan*
☐ Waive Vision Coverage

DEPENDENTS

TO ADD OR DROP DEPENDENTS, COMPLETE SECTION BELOW

You must submit required eligibility documentation and provide SSN for all dependent enrollments. See reverse side of form for list of required documents.

Medical	Dental	Vision	Last Name	First Name	MI	Full SSN	Date of Birth	Relationship
Add ☐ Drop ☐	Add ☐ Drop ☐	Add ☐ Drop ☐						
Add ☐ Drop ☐	Add ☐ Drop ☐	Add ☐ Drop ☐						
Add ☐ Drop ☐	Add ☐ Drop ☐	Add ☐ Drop ☐						
Add ☐ Drop ☐	Add ☐ Drop ☐	Add ☐ Drop ☐						

LIFE INSURANCE (*NON-SWORN EMPLOYEES ONLY*)

I appoint as revocable beneficiary(-ies) of insurance payable in the event of my death:

(Contingent beneficiaries are in the event if death of all primary beneficiaries)

Primary:

Name	Relationship	% of Benefit

Contingent:

Name	Relationship	% of Benefit

I certify that information on this document is true and correct and I give the person(s) administering the plans in which I enroll and/or their agents permission to verify any and all information. I agree to assume full financial responsibility for all expenses and to reimburse and indemnify the plans and the City of Oakland for any benefits paid for me and/or my dependents if I or my dependents subsequently prove to be ineligible to participate in the plans or to receive such benefits. I also understand that the falsification of information on this document may violate applicable laws, rules and regulations and could lead to disciplinary action, dismissal and/or legal action. I have read and accept the terms and conditions on this side and the reverse side of this form.

Your Signature:	Date:

PERS ENTRY:	ORACLE ENTRY:	EFECTIVE DATE:

PLEASE SEE THE REVERSE SIDE OF THIS FORM FOR ADDITIONAL INFORMATION

ENROLLMENT APPLICATION: TERMS AND CONDITIONS

- Your signature on the front of this form signifies your authorization, understanding of and agreement to the following:
- The City of Oakland **DHRM – Recruitment, Classification & Benefits Division** will only enroll you and your eligible dependents in the benefit elections indicated on this form and for which you are eligible.
- **You agree to submit any contribution required on your part directly to the** City of Oakland **DHRM – Recruitment, Classification, & Benefits Division during any unpaid leave of absence.**
- Your participation in the City of Oakland sponsored benefits is subject to all applicable laws, rules and regulations (including but not limited to, the rules and regulations of the City of Oakland) as the same may be amended, modified or supplemented from time to time.
- You will not be able to make any changes to the benefit elections indicated on this form during the Plan year (January 1-December 31) unless you have a qualifying family status change.
- Coverage may be canceled at anytime. If you elect to waive/cancel your City of Oakland sponsored medical, dental or vision coverage, you may re-enroll only during an Open Enrollment period, if you've experienced a recent (within 60 days) loss of other coverage, or be assessed a 90-day waiting period.
- Any misstatement of fact made by you with respect to the eligibility of any dependent or any other matter contained on this form will make you subject to disciplinary action, dismissal and/or legal action.
- You authorize any person, hospital or other entity that has rendered medical or dental services to you or any dependent(s) listed on this form to make available to the health plan, to such extent as may be lawful, any information, records or photographs regarding such services if requested by the health plan. Such information may also be released to persons or entities which, in conjunction with, or at the direction of the medical plan are conducting a review of cost, quality and/or appropriateness of services rendered.
- You agree that if you or any dependent listed on this form becomes ineligible at any time for the coverage available through the City of Oakland, you will promptly notify the City of Oakland **DHRM – Recruitment, Classification & Benefits Division** and submit all requested documentation.
- All healthcare services provided or benefits paid on behalf of any ineligible employee or dependent are subject to collection by the health plan involved or by the City of Oakland.
- If you elect to waive medical coverage, you must complete a Cafeteria / Medical Waiver Plan Form in addition to this form. Participation in the Waiver Program applies to an entire plan year. If participation in the Waiver program ends during the plan year and I again become eligible for the Cafeteria Plan within the same year, you must wait until the next plan year.
- The following documentation is required, in addition to a completed Employee Benefits Record Form, for any eligible individual's enrollment:

REQUIRED ELIGIBILITY DOCUMENTATION

	EBR	Marriage Cert.	Domestic Partner Cert.	Non-Tax Of Benefits	Birth Cert.	Adoption Cert.	Court Order	Tax Returns	Medical Evidence	PERS Affidavit
Employee	▪									
Spouse	▪	▪								
Domestic Partner	▪		▪	▪						
Natural Child	▪				▪					
Step Child	▪	▪			▪					
Domestic Partner Child	▪		▪		▪					
Adopted Child	▪					▪				
Child Legal Guardianship	▪						▪			
Economically Dependent Child	▪				▪			▪		▪
Disabled Child	▪								▪	
Court Order Child	▪						▪			

REQUIRED DOUCUMENTS TO CANCEL BENEFITS FOR SPOUSE/DOMESTIC PARTNER

	EBR	Dissolution of Marriage Certificate	Dissolution Domestic Partner Certificate
Employee	▪		
Spouse	▪	▪	
Domestic Partner	▪		▪

Where To Submit Forms:

- **Fax: 510-238-6560**
- **Email: BenefitsAdmin@oaklandca.gov**
- **Mail to: City of Oakland Benefits Unit**
  150 Frank H. Ogawa Plaza, 3rd Floor
  Oakland, CA 94612

CalPERS

P.O. Box 942715 Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377) | Fax: (800) 959-6545
www.calpers.ca.gov

California Public Employees' Retirement System

Pre-Retirement Lump Sum Beneficiary Designation

Section 1 Member Information

Please include your first name, middle initial and last name.

Member's Full Name _____ Social Security Number or CalPERS ID _____

Telephone Number _____ Birth Date _____

Section 2 Beneficiary Designation

Provide on the form the full name of your beneficiaries, relationship, Social Security number or CalPERS ID and the complete address.

If a percentage (%) is entered make sure the total equals 100%.

If the form does not provide enough space, you may attach additional sheets provided you indicate whether you are designating "primary" or "secondary" beneficiaries. You must sign, date and write your Social Security number or CalPERS ID at the top of each additional sheet.

I understand that if I am married or in a registered domestic partnership but do not name my spouse or registered domestic partner as beneficiary, she/he may still be entitled to a community property share of my "Lump Sum Contributions" or a share of any monthly allowance that may be payable. My "Non-Spouse" or "Non-Registered Domestic Partner" designated beneficiaries will receive the portion of my lump sum benefits, which are not payable to my spouse or registered domestic partner as his/her community property share. I further understand that if my death is determined to be "Industrial," special death benefits will be paid in the manner prescribed by law. If no percentage (%) is given, the applicable benefits will be paid **share and share alike**.

Primary Beneficiaries

Name of Primary Beneficiary _____ Birth Date _____

Relationship to the Member _____ Percentage of the Benefit _____ Social Security Number or CalPERS ID _____

Address (Number, Street, City, State and Zip Code) _____

Name of Primary Beneficiary _____ Birth Date _____

Relationship to the Member _____ Percentage of the Benefit _____ Social Security Number or CalPERS ID _____

Address (Number, Street, City, State and Zip Code) _____

Name of Primary Beneficiary _____ Birth Date _____

Relationship to the Member _____ Percentage of the Benefit _____ Social Security Number or CalPERS ID _____

Address (Number, Street, City, State and Zip Code) _____

Put your name and Social Security number or CalPERS ID at the top of every page.

Member's Name | Social Security Number or CalPERS ID

Section 2 Beneficiary Designation - Continued

If a percentage (%) is entered make sure the total equals 100%.

In the event that I survive the person(s) named above, I hereby designate the following person(s) who survive me, as BENEFICIARIES. If no percentage (%) is given, benefits will be paid **share and share alike**.

Secondary Beneficiaries

If the form does not provide enough space, you may attach additional sheets provided you indicate whether you are designating "primary" or "secondary" beneficiaries. You must sign, date and write your Social Security number or CalPERS ID at the top of each additional sheet.

Name of Secondary Beneficiary | Birth Date

Relationship to the Member | Percentage of the Benefit | Social Security Number or CalPERS ID

Address (Number, Street, City, State and Zip Code)

Name of Secondary Beneficiary | Birth Date

Relationship to the Member | Percentage of the Benefit | Social Security Number or CalPERS ID

Address (Number, Street, City, State and Zip Code)

Should I survive all of the persons named above, I understand that the benefits payable on account of my death will be paid to my statutory beneficiaries, or to such other beneficiary or beneficiaries that I may hereafter designate in writing to the Board of Administration, all in accordance with the applicable provisions of law.

Section 3 Required Signature(s)

Provide the date you signed the form and your current mailing address.

Member's Acknowledgement:

By this Beneficiary Designation, I hereby revoke any previous designation I have filed. I understand that my marriage or registered domestic partnership, dissolution or annulment of my marriage or registered domestic partnership, or the birth or adoption of a child or termination of membership subsequent to the date I file this form with CalPERS, will automatically void this designation. However, a designation filed after the initiation of a dissolution/annulment of marriage or registered domestic partnership is not revoked when the dissolution/annulment is finalized.

Are you legally married or have a registered domestic partner? ☐ Yes ☐ No

If yes, your spouse or registered domestic partner must sign this form. If no, please indicate:

☐ Never Married/Never in Registered Domestic Partnership ☐ Divorced/Annulled ☐ Widowed

If you are married or in a registered domestic partnership and your spouse or registered domestic partner **does not** sign this form, you must complete and submit the **Justification for Absence of Spouse's or Registered Domestic Partner's Signature** (my|CalPERS 0775) form with your designation form.

IMPORTANT - You must complete the Justification for Absence of Spouse's or Registered Domestic Partner's Signature (my|CalPERS 0775) if you are married or have a registered domestic partnership but your spouse or registered domestic partner is unable to sign below.

Member's Signature | Date (mm/dd/yyyy)

Member's Address | City | State | Zip Code

Spouse's/Registered Domestic Partner's Acknowledgement:

By signing this beneficiary designation form, I acknowledge the information entered by my spouse/ registered domestic partner.

Spouse's/Registered Domestic Partner's Signature | Date (mm/dd/yyyy)

Mail to: CalPERS Benefit Services Division · P.O. Box 942711, Sacramento, CA 94229-2711

my|CalPERS 0772

Section 4 Information and Instructions

Information

If you die before you retire, the Public Employees' Retirement Law provides for payment of specific Death Benefits to your surviving beneficiaries. Please order or download your Member Benefit Publication from our website www.calpers.ca.gov or see your personnel officer for a description of the benefits. The benefits are payable to the following beneficiaries:

A. If you are a safety member and your death is job-related, or if you are not a safety member but you are fatally attacked while performing your official job duties, the Special Death Benefit may be payable. This benefit is payable by law to your surviving spouse/registered domestic partner (whether or not you were still living together at the time of your death) or, if none, to your unmarried children/step-children under age 22, whether or not you have filed a beneficiary designation.

B. If you are eligible for retirement or you are a State member with at least 20 years of State service credit, a monthly death benefit allowance may be payable. If you do not have a valid beneficiary designation on file, the benefits will be payable to your surviving spouse/registered domestic partner to whom you have been married to or in a partnership with for either one year or prior to the onset of the injury or illness that resulted in death. Or, if there is no eligible surviving spouse/registered domestic partner, the allowance will be payable to your unmarried minor children, if any.

   If you do have a valid beneficiary designation on file, your spouse/registered domestic partner may still be entitled to a community property share of your lump sum contributions or monthly death benefit allowance. However, your non-spouse/non-registered domestic partner designated beneficiaries will receive the portion of your lump sum benefits that are not payable to your spouse/ registered domestic partner as his/her community property share.

C. If A and B do not apply and there is no valid Beneficiary Designation on file at the time of death, the benefits will be payable to your survivors in the following order:

   1. Your surviving spouse/registered domestic partner (whether or not you were still living together at the time of your death); or if none
   2. Natural and adopted children, including (in limited situations) a natural child adopted by another, share and share alike; or if none,
   3. Parents, share and share alike; or if none,
   4. Brothers and sisters, share and share alike, or if none,
   5. Your estate (if probated, or subject to probate), or if not,
   6. Your trust (if one exists), or if not,
   7. Stepchildren, share and share alike or if none,
   8. Grandchildren, including step-grandchildren, share and share alike, or if none,
   9. Nieces and nephews, share and share alike, or if none,
   10. Great-grandchildren, share and share alike, or if none,
   11. Cousins, share and share alike.

   If A and B do not apply and there is a valid Beneficiary Designation on file at the time of death, the benefits will be payable to the beneficiary(ies) you designate on the form. **However, if you are married or have a registered domestic partner at the time of death, your spouse/registered domestic partner may still be entitled to a community property share of your lump sum contributions.**

D. You may designate or change your beneficiaries at any time by completing another Beneficiary Designation form. You may name as beneficiary any person or persons, a corporation or your estate. Payment will be made to your estate only if probated. You may designate a trust as your beneficiary; however, you must provide the name of the trust, the date of the trust, and the name and address where the trust is filed. It is not necessary to provide the name of the trustee. Reminder: **If you are married or in a registered domestic partnership at the time of your death and you do not name your spouse/registered domestic partner as beneficiary, he/she may still be entitled to a community property share of your lump sum contributions or a share of any monthly allowance that may be payable.**

E. Your Beneficiary Designation will be revoked automatically, and benefits will be payable to the closest survivor listed in section C, if any of the following events occur after your designation form is received by CalPERS:
   1. Marriage/Registration of domestic partnership; or
   2. Dissolution or annulment of your marriage/registered domestic partnership. However, a designation filed after the initiation of a dissolution/annulment of marriage or registered domestic partnership is NOT revoked when the dissolution/annulment is finalized; or
   3. Birth or adoption of a child; or
   4. Termination of membership that results in a refund of your contributions.

Privacy Notice

The privacy of personal information is of the utmost importance to CalPERS. The following information is provided to you in compliance with the Information Practices Act of 1977 and the Federal Privacy Act of 1974.

Information Purpose

The information requested is collected pursuant to the Government Code (sections 20000 et seq.) and will be used for administration of Board duties under the Retirement Law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act, as the case may be. Submission of the requested information is mandatory. Failure to comply may result in CalPERS being unable to perform its functions regarding your status.

Please do not include information that is not requested.

Social Security Numbers

Social Security numbers are collected on a mandatory and voluntary basis. If this is CalPERS' first request for disclosure of your Social Security number, then disclosure is mandatory. If your Social Security number has already been provided, disclosure is voluntary. Due to the use of Social Security numbers by other agencies for identification purposes, we may be unable to verify eligibility for benefits without the number.

Social Security numbers are used for the following purposes:

1. Enrollee identification
2. Payroll deduction/state contributions
3. Billing of contracting agencies for employee/employer contributions
4. Reports to CalPERS and other state agencies
5. Coordination of benefits among carriers
6. Resolving member appeals, complaints, or grievances with health plan carriers

Information Disclosure

Portions of this information may be transferred to other state agencies (such as your employer), physicians, and insurance carriers, but only in strict accordance with current statutes regarding confidentiality.

Your Rights

You have the right to review your membership files maintained by the System. For questions about this notice, our Privacy Policy, or your rights, please write to the CalPERS Privacy Officer at 400 Q Street, Sacramento, CA 95811 or call us at 888 CalPERS (or 888-225-7377).

OKL

City of Oakland – Flexible Spending Arrangement Enrollment Form

Plan Year: 1/1/2021-12/31/2021 *with Grace Period through 3/15/2022*
Last Day to Submit Claims: 3/31/2022

navia benefit solutions

Employee Information – Please write legibly to ensure proper enrollment

Last Name, First Name			**Employee ID #**
Home Address (Street, City, State, Zip Code)			
Date of Birth	**Phone Number**	**Email Address**	**Effective Date**

Benefit Elections

Section 125 Benefit	Yes/No	Annual Election	# of Paychecks	Paycheck Deduction
Health Care FSA Maximum of $2,750.00 per plan year	❑ Yes ❑ No	$_____	26	$_____
Day Care FSA Maximum of $5,000.00 per plan year (or $2,500 if you're married and filing taxes separately)	❑ Yes ❑ No	$_____	26	$_____
Premium Conversion The group insurance premiums you pay through your paycheck are automatically deducted pre-tax. Premium contributions toward domestic partner coverage will be deducted post-tax unless they qualify as a tax dependent.				Automatic

Debit Card & Direct Deposit

Navia Debit Card – You may use the card to pay for expenses directly from the funds in your Health Care FSA. There is no cost for the initial card. The cards are valid for 3 year periods; if you've previously received the card then it will be reloaded with your new election. You must provide a valid email address to use the card.	Automatic
Direct Deposit – Reimbursements are electronically deposited into your bank account. You may sign up for direct deposit through your account on the Navia portal. If you've previously signed up for direct deposit with Navia your information will remain on file.	

Signature

This election form will remain in effect and cannot be revoked or changed during the plan year unless the revocation and new election are on account of and consistent with federal regulations. I understand that Health FSA reimbursements will be available only for qualifying medical care expenses for myself, spouse, and dependents. I also understand that Day Care reimbursements will be available only for qualifying day care expenses. I agree to notify the Employer if I have reason to believe that any expense for which I have obtained reimbursement is not a qualifying expense. I also agree to indemnify and reimburse the Employer on demand for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me. I understand the benefits and I have read the reverse page. I hereby authorize and direct my employer to reduce my salary by the amount necessary to pay for the benefit(s) as shown above for the plan year indicated above.

❑ **YES**, the above benefits have been explained to me and I elect to participate as indicated

❑ **NO**, the above benefits have been explained to me and I decline participation

Employee Signature	**Date**
X	

Completed Enrollment Forms must be returned to Human Resources

Please see the reverse side for important information regarding the above benefits

Additional Information

Premium Conversion

- If the enrollment status is marked as 'AUTOMATIC', you must notify your employer in writing to decline enrollment in this benefit. Premium Conversion is subject to the change in status rules and is considered an election equal to the amount of your premium deductions.

Health Care Flexible Spending Arrangement ("Health Care FSA")

- Reimbursement will only be available for qualifying medical care expenses as set forth in the Plan Document and Section 213 of the Internal Revenue Code. It is your responsibility to check the eligibility of an expense prior to enrollment.
- Group Medical Plan Premiums cannot be reimbursed through the Health Care FSA and will be deducted pre-tax through the Premium Conversion Plan. Therefore, do not include the cost of premiums in your FSA annual election amount.

Day Care Flexible Spending Arrangement ("Day Care FSA")

- Reimbursement will be available only for qualifying day care expenses as described in the Internal Revenue Code Section 129, the Plan document and the Summary Plan Description.
- Participation in a Day Care FSA will require you to complete tax form 2441 when filing federal taxes. If your plan includes a Grace Period any amounts carried forward or forfeited during a taxable year should be entered in Line 13 of Form 2441. If you or your spouse is a full-time student, please consult IRS Publication 503.
- If the Plan Year is less than twelve (12) months, the plan limit may be prorated to be less than the $5,000 calendar year limit mandated by the IRS.

Use-It or Lose-It

- You must claim all elected funds by the end of the run-out period. Money left in the plan after the end of the run-out period cannot be refunded to you; this is referred to as the Use-it or Lose-it rule.

Grace Period

- The grace period allows you to incur expenses against the prior plan year for 2 ½ months after the plan year ends. Expenses incurred after the end of the Grace Period are not eligible for reimbursement.

Claim Runout Period

- The claim runout period allows you to submit claims after the end of the plan year. Claims received after this period will be denied.

Lost Checks and Reissues

- Lost or stale dated FSA checks can be reissued 10 business days after the original check date. There is a $25.00 check reissue fee. The check reissue request will require at least one business day to process.
- Any fees associated with presenting a canceled check will be deducted from your FSA as well as the face value of the check.

Direct Deposit

- All electronic funds transfers (EFT) will be initiated on the same day as the normal check reimbursement date. Deposits may take up to two (2) business days to appear in the designated account.
- Returned items due to incorrect banking information will be assessed a $10.00 fee that will be deducted from your FSA balance.

Deductions

- FSA deductions will be deducted from your paycheck evenly throughout the plan year. You must indicate an annual election and a per paycheck deduction on your enrollment form. If you enroll in the plan after open enrollment then please divide your annual election by the remaining deductions in the plan year.

Change in Status

- All elections set forth are considered irrevocable for the entire plan year unless there is a qualifying change in status. Please consult the plan document or summary plan description for a list of qualifying events.
- In the event of a change in status the change in election must be necessitated by and consistent with the change in status and the change must be acceptable under IRS Regulations.

Eligibility

- Independent contractors and self-employed individuals are not eligible to participate in the Plan. Self-employed individuals include: Sole Proprietors of their own business; General Partners in a general partnership and General Partners in a limited partnership; Limited Partners of partnerships with guaranteed payments; more than 2% Shareholders of an S corporation as well as the spouse, children, parents and grandparents of a more than 2% Shareholder; and non-employee Members of an LLC. It is your responsibility to determine your eligibility.
- Expenses must be incurred during the plan year and while you are an active participant in the plan. Any expense incurred prior to your effective date or after your termination date cannot be reimbursed.

Debit Card

- If you elect to use the card please keep in mind that you may still need to submit supporting documentation to verify that a charge is eligible. You will be notified via email if you have a charge that requires documentation. You can check your account online to view any outstanding charges or contact customer service.
- If you use the card for an ineligible expense or do not substantiate a charge within 75 days of receiving the first request for substantiation your card may be temporarily suspended to prevent further use. The IRS provides the participant with 2 methods for correcting an ineligible or unsubstantiated charge: a) repay the plan for the amount of the expense, or b) request the substitution or offset of future out of pocket expenses. If neither option "a" nor "b" is successful the final option illustrated by the IRS permits the employer to deduct the ineligible expense from the participant's wages or other compensation consistent with federal and state law.
- You will receive one card by default but you can request additional cards for a fee of $5/card. This fee also applies for reissues of any lost, stolen, or otherwise misplaced cards. The $5 fee will be deducted from your FSA balance.

Electronic Disclosure Notice

- By providing your email address you consent to receive email communications from Navia, agents, and subcontractors regarding the Plan.
- If you no longer wish to receive information electronically, you may withdraw consent at any time at no cost. To withdraw consent, please contact Navia.
- You have a right to receive a paper version of an electronically furnished document at no cost.
- To access documents you must have Adobe Reader. A link to download this software will be provided with all electronic documents provided.

CITY OF OAKLAND

PREDESIGNATION OF PERSONAL PHYSICIAN

In the event you sustain an injury or illness related to your employment, you may be treated for such injury or illness by your personal medical doctor (M.D.), doctor of osteopathic medicine (D.O.) or medical group if:

- on the date of your work injury you have health care coverage for injuries or illnesses that are not work related;
- the doctor is your regular physician, who shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner, and has previously directed your medical treatment, and retains your medical records;
- your "personal physician" may be a medical group if it is a single corporation or partnership composed of licensed doctors of medicine or osteopathy, which operates an integrated multispecialty medical group providing comprehensive medical services predominantly for nonoccupational illnesses and injuries;
- prior to the injury your doctor agrees to treat you for work injuries or illnesses;
- prior to the injury you provided your employer the following in writing: (1) notice that you want your personal doctor to treat you for a work-related injury or illness, and (2) your personal doctor's name and business address.

You may use this form to notify your employer if you wish to have your personal medical doctor or a doctor of osteopathic medicine treat you for a work-related injury or illness and the above requirements are met.

NOTICE OF PREDESIGNATION OF PERSONAL PHYSICIAN

Employee: Complete this section.

To: _____ (name of employer) If I have a work-related injury or illness, I choose to be treated by:

_____
(name of doctor)(M.D., D.O., or medical group)

_____ (street address, city, state, ZIP)

_____ (telephone number)

Employee Name (please print):

_____

Employee's Address:

_____

Name of Insurance Company, Plan, or Fund providing health coverage for nonoccupational injuries or illnesses:

_____

Employee's Signature _____Date: _____

Physician: I agree to this Predesignation:

Signature: _____ _____Date: _____
(Physician or Designated Employee of the Physician or Medical Group)

The physician is not required to sign this form, however, if the physician or designated employee of the physician or medical group does not sign, other documentation of the physician's agreement to be predesignated will be required pursuant to Title 8, California Code of Regulations, section 9780.1(a)(3).

Title 8, California Code of Regulations, section 9783.
(Optional DWC Form 9783 July 1, 2014)

Authority: Sections 133, 4603.5 and 5307.5, Labor Code.
Reference: Section 4600, Labor Code.

DWCC: Make 3 copies
Original: Personnel file
Copies to: Employee, TPA, DWCC for Department File

Received by: _____

Date:_____

Revision: May 2014

NOTICE OF PERSONAL CHIROPRACTOR OR PERSONAL ACUPUNCTURIST

If your employer or your employer's insurer does not have a Medical Provider Network, you may be able to change your treating physician to your personal chiropractor or acupuncturist following a work-related injury or illness. In order to be eligible to make this change, you must give your employer the name and business address of a personal chiropractor or acupuncturist in writing prior to the injury or illness. Your claims administrator generally has the right to select your treating physician within the first 30 days after your employer knows of your injury or illness. After your claims administrator has initiated your treatment with another doctor during this period, you may then, upon request, have your treatment transferred to your personal chiropractor or acupuncturist.

NOTE: If your date of injury is January 1, 2004 or later, a chiropractor cannot be your treating physician after you have received 24 chiropractic visits unless your employer has authorized additional visits in writing. The term "chiropractic visit" means any chiropractic office visit, regardless of whether the services performed involve chiropractic manipulation or are limited to evaluation and management. Once you have received 24 chiropractic visits, if you still require medical treatment, you will have to select a new physician who is not a chiropractor. This prohibition shall not apply to visits for postsurgical physical medicine visits prescribed by the surgeon, or physician designated by the surgeon, under the postsurgical component of the Division of Workers' Compensation's Medical Treatment Utilization Schedule.

You may use this form to notify your employer of your personal chiropractor or acupuncturist.

Your Chiropractor or Acupuncturist's Information:

_____

(name of chiropractor or acupuncturist)

_____

(street address, city, state, zip code)

_____

(telephone number)

Employee Name **(please print)**:

_____

Employee's Address:

_____

Employee's Signature_____Date: _____

Title 8, California Code of Regulations, section 9783.1.
(Optional DWC Form 9783.1 Effective date July 1, 2014)

DWCC: Make 3 copies
Original: Personnel file
Copies to: Employee, TPA, DWCC for Department File

Received by: _____

Date:_____

ICMA-RC

CITY OF OAKLAND
Retirement Plans
Helping Your Future Take Root

Express Enrollment Form
457 Deferred Compensation Plans

- Carefully complete all sections of this form in blue or black ink.
- Submit the completed form to your employer to enroll in the ICMA-RC 457 Deferred Compensation Plan.

1. PERSONAL INFORMATION

Employer Plan Number: **307108** Employer Plan Name: **City of Oakland**

Social Security Number: (For tax reporting purposes) _____ - _____ - _____ Date of Birth: _____ / _____ / _____ *(MM/DD/YYYY)*

Name: _____ Rehired? ☐ Check if yes
Last First MI

Street: _____ City: _____ State: _____ Zip: _____ - _____

Mobile Phone Number: (_____) - _____ - _____ Date Employed/Rehired: _____ / _____ / _____ *(MM/DD/YYYY)*

Gender: ☐ M ☐ F Marital Status: ☐ Married ☐ Single Email: _____

2. INVESTMENT SELECTION

By submitting this form, you understand you have not chosen an investment option. To select an investment option, log into www.icmarc.org/login once your account is established. If you do not select an investment option, you entire account will be invested in the Plan's default investment selection.

3. CONTRIBUTION ELECTION

Specify the total percentage or dollar amounts you wish to contribute each pay period. Contributions will begin as soon as administratively possible following the month in which this form is submitted.

Pre-tax contributions of _____% or $_____ from my pay each pay period.

Roth* contributions of _____% or $_____ from my pay each pay period.

** NOT available in all plans. Please check with your employer to confirm that Roth Contributions are offered in your plan before selecting this option.*

4. BENEFICIARY DESIGNATIONS

Once your account has been established, log in to your account at www.icmarc.org/login to setup your beneficiary designations.

5. SIGNATURES

Sign, date, and submit the completed form to your employer.

_____ Date_____ / _____ / _____ *(MM/DD/YYYY)*
Employee Signature

_____ Date_____ / _____ / _____ *(MM/DD/YYYY)*
Authorized Employer Official's Signature

_____ _____
Authorized Employer Official's Name (Please print) Authorized Employer Official's Title

PLEASE KEEP A COPY OF THE COMPLETED FORM FOR YOUR RECORDS