Employee Benefits 2023 Guide

Sworn Fire

Employee Benefits Guide

SWORN FIRE

2023

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NEW! Click this icon in your benefits guide to watch a video explaining the associated topic.

NEW! See page 38 for a glossary of terms.

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

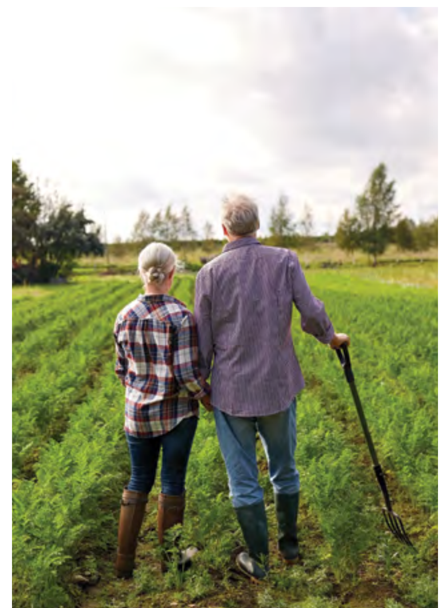
- CalPERS Medical
- Dental
- Medical Waiver Plan – Cash-In-Lieu
- Flexible Spending Accounts
- Employee Assistance Program (EAP)
- Commuter Benefits Guaranteed Ride Home (GRH)
- Pension Benefits
- Deferred Compensation

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
Benefit Enrollment Questions and General Benefit Questions	**Benefits Unit**	benefitsadmin@oaklandca.gov
Benefits Supervisor	**Tami Honda**	510.238.6891 thonda@oaklandca.gov
COBRA	**Navia Benefits Solutions**	877.920.9675 cobra@naviabenefits.com
Deferred Compensation	**Michael McGhee ICMA-RC** (Investment Option Inquiry Only)	510.238.6485 mmcghee@missionsq.org
	Jeanette Delgado	510-238-7445 jdelgado@oaklandca.gov
Medical & Dental	**Adrienne Cooper**	510.238.6474 acooper2@oaklandca.gov
Other Benefits		
• Flexible Spending Arrangement Program • Health Care FSA • Day Care FSA • Commuter Benefits	**Adrienne Cooper**	510.238.6474 acooper2@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 • Unemployment (EDD)	Erika Turner	510.238.7660 eturner@oaklandca.gov
• Employee Assistance Program • IAQ *(Indoor Air Quality)* • Threat Assessment • CAL/OSHA Programs	Greg Elliott	510.238.4993 gelliott@oaklandca.gov
• Ergonomics • Safety, Health & Wellness	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)* • Pregnancy Disability and Bonding	Donella Williams	510.238.6488 dwilliams3@oaklandca.gov

Contact Information (continued)

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

Benefit information and forms can be located at:

www.oaklandca.gov/benefits

Employee Benefits Program	Phone Number	Web Site
Medical		
• CalPERS	888.225.7377	https://my.calpers.ca.gov
Dental		
• IAFF Dental	925.833.4363 **or** 925.833.4323	OaklandFireDental@HSBA.com
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

2023 Payroll Processing and Holiday Calendar

January
1 New Year's Day

2 New Year's Day (Observed)

16 Martin Luther King Jr. Day

February
20 President's Day

March
31 Cesar Chavez Day

May
29 Memorial Day

June
19 Juneteenth National Independence Day

July
4 Independence Day

September
4 Labor Day

9 Admissions Day (HVA)*

November
11 Veteran's Day (HVA)*

23 Thanksgiving Day

24 Day after Thanksgiving Day

December
25 Christmas Day

*If applicable

JANUARY

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DECEMBER

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Pay Period Ends

Pay Dates

Holidays

2023 Holiday Schedule

Holidays

- January 1st
- Martin Luther King, Jr. Day - the third Monday in January
- President's Day - the third Monday in February
- Cesar Chavez Day - March 31st
- Memorial Day - the last Monday in May
- Juneteenth National Independence Day - June 19th
- July 4th
- Labor Day - the first Monday in September
- Admissions Day - September 9th
- Veteran's Day - November 11th
- Thanksgiving Day - the Thursday in November appointed
- Christmas - December 25th
- Two (2) floating holidays

Holiday In Lieu Pay

In lieu of observing holidays, bargaining unit members shall receive in lieu compensation for holidays without regard for when holidays occur or whether the unit member actually works on a holiday. In lieu holiday compensation shall be paid to 24 hour shift unit members at the rate of 6.27 hours per pay period and to 40 hour per week unit members at the rate of 4.82 hours per pay period. This in- lieu holiday pay meets the definition of special compensation defined in Cal. Code of Regs., Title 2, Section 571, and shall be incorporated into the unit member's compensation reported to CalPERS for retirement purposes. In the event PERS modifies its regulation, the parties agree to meet and negotiate to amend the language of Section 2.6.2.

Additional Holiday

If and when the City declares an additional holiday, in lieu holiday compensation shall be paid to 24 hour shift employees at the rate of 6.75 hours per pay period and to 40 hour per week employees at the rate of 5.19 hours per pay period.

Refer to your labor agreement for more information.

Rates: Sworn Fire Employees

Monthly Medical Plan Rates for Sworn Fire Employees

Effective January 1, 2023

In addition to the monthly employee contribution rates below, sworn fire employees pay an additional $5.00 contribution each pay period.

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	$1,200.12	$2,400.24	$3,120.31	$286.38	$572.76	$744.59
Anthem Select HMO	$1,128.83	$2,257.66	$2,934.96	$215.09	$430.18	$559.24
Anthem Traditional HMO	$1,210.71	$2,421.42	$3,147.85	$296.97	$593.94	$772.13
Blue Shield Access+ HMO	$1,035.21	$2,070.42	$2,691.55	$121.47	$242.94	$315.83
Blue Shield Access+ EPO	$1,035.21	$2,070.42	$2,691.55	$121.47	$242.94	$315.83
Blue Shield Trio	$888.94	$1,777.88	$2,311.24	$0.00	$0.00	$0.00
Health Net SmartCare HMO	$1,174.50	$2,349.00	$3,053.70	$260.76	$521.52	$677.98
Kaiser (CA) HMO	$913.74	$1,827.48	$2,375.72	$0.00	$0.00	$0.00
PERS Gold	$825.61	$1,651.22	$2,146.59	$0.00	$0.00	$0.00
PERS Platinum	$1,200.12	$2,400.24	$3,120.31	$286.38	$572.76	$744.59
PORAC *(POLICE ONLY)*	$825.00	$1,875.00	$2,300.00	$0.00	$47.52	$0.00
United HealthCare HMO	$1,044.07	$2,088.14	$2,714.58	$130.33	$260.66	$338.86
Western Health Advantage	$760.17	$1,520.34	$1,976.44	$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	$765.37	$1,530.74	$1,989.96	$0.00	$0.00	$0.00
Anthem Traditional HMO	$935.12	$1,870.24	$2,431.31	$21.38	$42.76	$55.59
Blue Shield Access+ HMO	$842.61	$1,685.22	$2,190.79	$0.00	$0.00	$0.00
Blue Shield Access+ EPO	$842.61	$1,685.22	$2,190.79	$0.00	$0.00	$0.00
Blue Shield Trio	$760.71	$1,521.42	$1,977.85	$0.00	$0.00	$0.00
Health Net Salud y Mas	$698.91	$1,397.82	$1,817.17	$0.00	$0.00	$0.00
Health Net SmartCare HMO	$834.65	$1,669.30	$2,170.09	$0.00	$0.00	$0.00
Kaiser (CA) HMO	$756.21	$1,512.42	$1,966.15	$0.00	$0.00	$0.00
PERS Gold	$695.93	$1,391.86	$1,809.42	$0.00	$0.00	$0.00
PERS Platinum	$1,014.80	$2,029.60	$2,638.48	$101.06	$202.12	$262.76
PORAC *(POLICE ONLY)*	$820.00	$1,650.00	$2,100.00	$0.00	$0.00	$0.00
Sharp	$764.96	$1,529.92	$1,988.90	$0.00	$0.00	$0.00
United HealthCare HMO	$793.63	$1,587.26	$2,063.44	$0.00	$0.00	$0.00
United HealthCare Harmony HMO	$871.58	$1,563.16	$2,032.11	$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: Sworn Fire Employees (continued)

Monthly Medical Plan Rates for Sworn Fire Employees

Effective January 1, 2023

In addition to the monthly employee contribution rates below, sworn fire employees pay an additional $5.00 contribution each pay period.

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	$737.91	$1,475.82	$1,918.57	$0.00	$0.00	$0.00
Anthem Traditional HMO	$942.73	$1,885.46	$2,451.10	$28.99	$57.98	$75.38
Blue Shield Access+ HMO	$738.29	$1,476.58	$1,919.55	$0.00	$0.00	$0.00
Blue Shield Trio	$661.49	$1,322.98	$1,719.87	$0.00	$0.00	$0.00
Health Net Salud y Mas	$606.34	$1,212.68	$1,576.48	$0.00	$0.00	$0.00
Health Net SmartCare HMO	$755.29	$1,510.58	$1,963.75	$0.00	$0.00	$0.00
Kaiser (CA) HMO	$754.64	$1,509.28	$1,962.06	$0.00	$0.00	$0.00
PERS Gold	$680.37	$1,360.74	$1,768.96	$0.00	$0.00	$0.00
PERS Platinum	$992.59	$1,985.18	$2,580.73	$78.85	$157.70	$205.01
PORAC *(POLICE ONLY)*	$820.00	$1,600.00	$2,100.00	$0.00	$0.00	$0.00
United HealthCare HMO	$790.46	$1,580.92	$2,055.20	$0.00	$0.00	$0.00
United HealthCare Harmony HMO	$713.55	$1,427.10	$1,855.23	$0.00	$0.00	$0.00

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
Kaiser Out of State	$1,155.43	$2,310.86	$3,004.12	$241.69	$483.38	$628.40
PERS Platinum	$1,003.90	$2,007.80	$2,610.14	$90.16	$180.32	$234.42
PORAC (POLICE ONLY)	$935.00	$1,899.00	$2,250.00	$21.26	$71.52	$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.

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
- Cafeteria Plan Election form (Medical Waiver)
- Spouse and child coverage available to employees who are enrolled
- Pre-designation of Personal Physician
- Notice of Personal Chiropractor or Personal Acupuncturist

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 Benefits Unit. 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, you may enroll online on the Mission Square site or submit a paper enrollment form. Online enrollment or enrollment paperwork needs to be completed (and submitted to our office if using a paper enrollment form) by the 15th of the month; deductions will begin by 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 or emailed to benefitsadmin@oaklandca.gov.

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, a dental plan, group life insurance coverage, and optional voluntary benefits.

Eligibility

Employees

The City of Oakland offers Medical and Dental to sworn fire employees and their eligible dependents.

Employees may waive medical coverage and receive a monthly medical waiver premium with proof of other health coverage.

To elect the medical waiver plan you must:

- Complete the Medical Waiver Form
- Complete the Employee Benefits Record Form
- Provide proof of other coverage in the form of a letter. Insurance cards are not accepted

The Medical Waiver Premium amounts are based off your represented unit. Please refer to your MOU for the premium amounts.

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)

For purposes of sworn fire dental plan coverage, eligible dependents are as follows:

- A spouse
- Child (up to age 26) for whom you have a parent-child relationship
- A registered domestic partner of an employee

Active Employment

Employees who are eligible to participate in the medical and dental group insurance plans are sworn fire employees.

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, the vision plan or choose the cash in lieu option (waiver). You may also add or delete dependents to your medical or dental 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
- Oakland Firefighters Health & Welfare Dental Enrollment 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, 150 Frank Ogawa Plaza, 2nd Floor front counter or you can fax your forms to 510.238.6560.

All benefits forms can also be found on the City of Oakland's Benefit webpage at 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 beneficiary forms on the City's benefit webpage at www.oaklandca.gov/benefits. You can designate a beneficiary for:

- Deferred Compensation
- 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.

Click here to watch a video on Qualifying Life Events.

2023 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 access the SBCs and glossary online, visit www.calpers.ca.gov and select **View Health Plan Rates** to access the **Plans & Rates** page, or visit any of the health plan websites below. To request a free paper copy of the SBC and glossary, contact each health plan directly.

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

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

California Association of Highway Patrolmen[1]
800.734.2247
www.thecahp.org

California Correctional Peace Officers Association[1]
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[1]
800.288.6928
http://ibt.porac.org

PERS Gold and PERS Platinum
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

1 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.

Click here to watch a video on Health Maintenance Organizations (HMO).

Click here to watch a video on Preferred Provider Organizations (PPO).

Click here to watch a video on PPO vs HMO.

- **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.

2023 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 HMO Harmony HMO	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 Charge	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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2023 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	Blue Shield	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue	Western Health Advantage HMO
	EPO Select HMO Traditional HMO	Access+ HMO & Access+ EPO Trio HMO	Salud y Más & SmartCare			Alliance HMO Harmony 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 *(30-day supply)*	Tier 1: $5 Tier 2: $20 Tier 3: $50	Generic/Tier 1[1]: $5 Brand Preferred/Tier 2[1]: $20 Non-Preferred/Tier 3[1]: $50 Tier 4[1]: $30	Tier 1: $5 Tier 2: $20 Tier 3: $50	Generic: $5 Brand: $20	Tier 1: $5 Tier 2: $20 Tier 3: $50	Tier 1: $5 Tier 2: $20 Tier 3: $50	Tier 1: $5 Tier 2: $20 Tier 3: $50
• Retail Preferred Pharmacy Maintenance Medications *(90-day supply)*	Tier 1: $10 Tier 2: $40 Tier 3: $100	Generic/Tier 1[1]: $10 Brand Preferred/Tier 2[1]: $40 Non-Preferred/Tier 3[1]: $100 Tier 4[1]: $60	Tier 1: $10 Tier 2: $40 Tier 3: $100	N/A	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100
• Mail Order Pharmacy Program *(not to exceed 90-day supply for maintenance drugs)*	Tier 1: $10 Tier 2: $40 Tier 3: $100	Generic/Tier 1[1]: $10 Brand Preferred/Tier 2[1]: $40 Non-Preferred/Tier 3[1]: $100 Tier 4[1]: $60	Tier 1: $10 Tier 2: $40 Tier 3: $100	Generic: $10 Brand: $40 (31-100 day supply	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100
• Mail order maximum copayment per person per calendar year	$1,000	$1,000	$1,000	N/A	$1,000	$1,000	$1,000

1 Tier formulary BSC Trio HMO only

Tier 1 refers to medications classified as 'Generic'; Tier 2 refers to medications classified as "Preferred Brand"; and Tier 3 refers to medications classified as "Non-Preferred Brand".

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2023 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 HMO Harmony HMO	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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2023 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 Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Calendar Year Deductible						
• Individual	$1,000[1,3]		$500[3]		$300	$600
• Family	$2,000[1,3]		$1,000[3]		$900	$1,800
Maximum Calendar Year Copay or Coinsurance *(excluding pharmacy)*						
• Individual	$3,000 (coinsurance)	Unlimited	$2,000 (coinsurance)	Unlimited	$2,000	Unlimited
• Family	$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]	10%	40%[4]	20%	20%[4]
• Outpatient Facility/ Surgery Services	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 facility charge only)		N/A	
• Emergency	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%	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)			

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 Gold and PERS Platinum.

4 Of the allowable amount as defined in the EOC.

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2023 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 Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Physician Services *(including Mental Health and Substance Abuse)*						
• Office Visits *(copay for each service provided)*	$35[1]	40%[3]	$20[2]	40%[3]	$10/$35[1]	20%[3]
• Inpatient Visits	20%	40%[3]	10%	40%[3]	20%	20%[3]
• Outpatient Visits	$35	40%[3]	$20	40%[3]	20%	20%[3]
• Urgent Care Visits	$35	40%[3]	$20	40%[3]	$35	20%[3]
• Preventive Services	No Charge	40%[3]	No Charge	40%[3]	No Charge	
• Surgery/Anesthesia	20%	40%[3]	10%	40%[3]	20%	20%[3]
Diagnostic X-Ray/Lab						
	20%	40%[3]	10%	40%[3]	20%	20%[3]

1 Reduced to $10 when seen by primary physician

2 $35 for specialist visit

3 Of the allowable amount as defined in the EOC

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2023 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 Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Prescription Drugs						
• Deductible	N/A		N/A		N/A	
• Retail Pharmacy *(30-day supply)*	Tier 1: $5 Tier 2: $20 Tier 3: $50		Tier 1: $5 Tier 2: $20 Tier 3: $50		Generic: $10 Brand Formulary: $25 Non-Formulary: $45 Compound: $45	
• Retail Preferred Pharmacy Maintenance Medications	Tier 1: $10 Tier 2: $40 Tier 3: $100		Tier 1: $10 Tier 2: $40 Tier 3: $100		N/A	
• Mail Order Pharmacy Program *(not to exceed 90-day supply for maintenance drugs)*	Tier 1: $10 Tier 2: $40 Tier 3: $100		Tier 1: $10 Tier 2: $40 Tier 3: $100		Generic: $20 Brand Formulary: $40 Non-Formulary: $75	N/A
• Mail order maximum copayment per person per calendar year	$1,000		$1,000		N/A	
Durable Medical Equipment						
	20%	40% [1]	10%	40% [1]	20%	20%[1]
	(pre-certification required for equipment)		(pre-certification required for the purchase of equipment priced at $1,000 or more)			

1 Of the allowable amount as defined in the EOC

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2023 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 Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Infertility Testing/Treatment						
	50%		50%		50%	50%[2]
Occupational / Physical / Speech Therapy						
• Inpatient *(hospital or skilled nursing facility)*	No Charge		No Charge		20% (no copay for inpatient PT/OT by a PAR provider)	20%[2]
• Outpatient *(office and home visits)*	20%	40% (Occupational therapy 20%)	10%	40% (Occupational therapy 20%)	$15/visit (all other services 20%)[3]	20%[2]
	(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	
• Self-management training	$20[1]	40%[2]	$20[1]	40%[2]	$20	60%[2]
Acupuncture						
	$15/visit	40%[2]	$15/visit	40%[2]	$15	20%[2]
	(acupuncture/chiropractic combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(all other services 20%)[3]	
Chiropractic						
• Office Visit	$15/visit	40%[2]	$15/visit	40%[2]	$15/visit	20%[2]
	(acupuncture/chiropractic combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(combined 20 visits per calendar year)	

1 $35 for specialist visit
2 Of the allowable amount as defined in the EOC
3 Combined 20 visits per calendar year. Speech therapy is not included in the 20 visit per calendar year combination; see EOC for Speech Therapy benefit.

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Other Benefits

Dental

Dental benefits are administered through IAFF Local 55. Please contact HS&BA (Health Services & Benefits Administration) at 925.833.4363 or 925.833.4323 or OaklandFireDental@HSBA.com for more information.

Employee Assistance Program (EAP)

This program is offered by the City of Oakland to help employees and their families cope with difficult personal issues. The Employee Assistance Program (EAP) has counselors on staff, as well as referrals to outside resources. It is offered off-site and is strictly confidential.

Why this Service?

Personal concerns can impact your work performance and overall functioning. The EAP helps you resolve personal issues before they become more serious and difficult to manage.

Who provides the EAP?

Claremont is a firm of select professionals who can help you with life's challenges. You will be referred to a conveniently located counselor or resource with expertise in your area of concern.

Counseling Visits

The EAP offers free short-term counseling visits for almost any personal issue. Claremont will work with you to find the most appropriate counselor to meet your needs.

- Marital/relationship issues
- Parenting/family issues
- Work concerns
- Depression
- Anxiety
- Stress
- Substance abuse
- Other issue impacting your quality of life

Work/Life Referrals

Work/Life consultants can provide you with referrals and information for services such as:

- Child care
- Elder care
- Pet care
- Adoption assistance
- School/college assistance
- Health and wellness
- Convenience referrals

Legal Consultation

Attorneys are available to answer your legal questions, either in-person or over the phone. Up to 30 minutes of free consultation per incident is provided. On-going services, if required, are offered at a discount. The EAP can assist with legal issues such as:

- Divorce
- Child custody
- Real estate
- Personal injury
- Criminal law
- Free sample will kits

Financial Consultation

The EAP offers telephonic consultation on a variety of important financial issues, including:

- Budgeting
- Debt management
- Financial planning
- First time home buyer program
- Tax questions
- Identity fraud service
- Free credit report/review

For more information, please call 800.834.3733 or visit claremonteap.com.

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 2023, the maximum contribution amount is $3,050.

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.

Click here to watch a video on Flexible Spending Accounts (FSA).

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 2023, the pre-tax parking limit is $300.00 per month.
- For 2023, the pre-tax transit and van pooling limit is $300.00 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 Local 55 members must make retirement contributions through bi-weekly payroll deductions.

- **The current retirement formulas for Local 55 sworn employees are:**
  - **Tier One: Enhanced Safety 3% @ 50 Retirement Program - Unit Members Hired Before July 1, 2011.**
    - **3% @ 50 Pension Formula**
    - **Final Compensation Based on Twelve Month Period.** Final compensation will be based on the highest twelve consecutive month period as specified in Government Code Section 21362.2.
    - **Required Employee Contribution** - Each member shall pay a total of 13.0% of PERSable compensation towards the unit member's normal cost and the City's normal cost of pension benefits. This includes 12% of PERSable compensation toward the normal cost of pension benefits and an additional 1.0% PERSable compensation towards the City's normal cost of pension benefits.
  - **Tier Two: Safety 3% @ 55 Retirement Program - Unit Members Hired on or After July 1, 2011.** Unit members hired on or after July 1, 2011 and on or before December 31, 2012. 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(c) and related CalPERS reciprocity requirements**.**
    - **3% @ 55 Pension Formula**
    - **Final Compensation Based on Thirty-Six Months** - Final compensation will be based on the highest annual average pensionable compensation earned during thirty-six (36) consecutive months of service.
    - **Required Employee Contribution** - Each member shall pay a total of 13.0% of PERSable compensation towards the unit member's normal cost and the City's normal cost of pension benefits. This includes 12% of PERSable compensation toward the normal cost of pension benefits and an additional 1.0% PERSable compensation towards the City's normal cost of pension benefits.
  - **Tier Three: Safety Bargaining 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% @ 50 - 2.7% @ 57 Pension Formula**
    - **Final Compensation Based on Three Year Average** - Final compensation will be based the highest annual average pensionable compensation earned during 36 consecutive months of service.
    - **Required employee contribution –** Each member shall pay fifty percent (50%) of normal costs. In the event that fifty percent (50%) of normal costs is less than thirteen percent (13%), sworn Local 55 employees eligible for Tier Three shall pay 50% of normal costs and an additional percentage of PERSable compensation up to a maximum of 13.0% toward the City's normal cost of pension benefits as permitted by Government Code Section 20516.

Please refer to your Local 55 Memorandum of Understanding (MOU) for more information.

Other Benefits (continued)

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

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 510.238.6891.

Important Notices

No Surprises Act Notice

Our medical plans are subject to the No Surprises Act, which limits the amount covered persons may have to pay for certain out-of-network surprise medical bills. More information about surprise billing requirements included under the No Surprises Act and similar state laws, can be found on the medical insurance company's website or the Plan Sponsor's website. Additional information may be found in your Explanation of Benefits for any affected claims.

Discrimination Is Against the Law

The City of Oakland complies with the applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics). The City of Oakland does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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 to this minimum length of stay. Early discharge is permitted only 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) 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 covered medical, dental and vision plans (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.

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 of a Qualifying Event:

- The end of employment or reduction of hours of employment;
- Death of the employee; or,
- The employee 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, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted 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.

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.

Important Notices (continued)

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

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

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

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

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

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

IF YOU HAVE QUESTIONS

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

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

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

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.

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 the 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.

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 the 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, 2023
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 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 November 1, 2022, and is anticipated to end on January 31, 2023. Open Enrollment for most other states will begin on November 1 and close on January 15 of each year. Some states have expanded the open enrollment period beyond January 15, 2023 for coverage to begin in 2023. Notably, Covered California continues its special enrollment periods for coverage beginning in 2023.

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 9.12% (for 2023) 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. If you receive a premium savings for Marketplace coverage, the IRS may seek reimbursement of those funds.

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: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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. The information is numbered to correspond to the Marketplace application.

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@oaklandca.com	

As your employer, we offer coverage that meets the minimum value standard to the employees as described in this Guide. The coverage offered to you meets the minimum value standard and the cost of this coverage to you is intended to be affordable based on employee wages.

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, 2022. 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:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHIP+)
Health 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
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp/
Phone: 678-564-1162, press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, press 2

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
Hawki Phone: 800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
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
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)

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: https://www.mass.gov/masshealth/pa
Phone: 800-862-4840
TTY: 617-886-8102

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
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov/
Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
HIPP Program Toll-Free Phone: 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/Services/Assistance/Pages/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

Important Notices (continued)

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/en/famis-select
https://www.coverva.org/en/hipp/
Medicaid Phone: 800-432-5924
CHIP Phone: 800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP 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, 2022, 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

Glossary

Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, reduced FSA contributions, covering preventive care without cost-sharing, etc, among other requirements.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Brand Name Drug

The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

The Consolidated Omnibus Budget Reconciliation Act allows people who lose their jobs to continue their employer-sponsored insurance coverage for up to 18 months.

Children's Health Insurance Program (CHIP)

The government program that provides free or low-cost health coverage for children up to age 19 in families whose income is too high to qualify for Medicaid but too low to afford private insurance. CHIP covers U.S. citizens and eligible immigrants. In some states, CHIP covers pregnant people. CHIP goes by different names in some states.

Claim

A request for payment that you or your health care provider submits to your health insurer to be paid or reimbursed for items or services you have received. Most often, you will not be responsible for making claim requests. Usually, billing and claims specialists employed by the health care provider (e.g. primary care office, hospital) will make the claim on your behalf.

Coinsurance

A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)

A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Comprehensive Coverage

A health insurance plan that covers the full range of care that you may need. This may include preventive services (like flu shots), physical exams, prescription drugs, and doctor or hospital care.

Deductible

The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Formulary

A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Generic Drug

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)

High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

Glossary (continued)

Health Savings Account (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax- free basis. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Health Reimbursement Arrangements (HRAs)

Unlike HSAs, only an employer may fund an HRA and the funds revert back to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs, and they may be paired with either high-deductible plans or traditional health plans.

In-Network

Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Out-of-Pocket Maximum

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Out-Of-Network

A health plan will cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-Of-Pocket Limit

The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including co-payments and co-insurance.

Plan Year

The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Premium

The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

Preventive Care

Health care services you receive when you are not sick or injured— so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

Qualifying Life Event

A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include moving to a new state, certain changes in your income, and changes in your family size.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Click here to watch a video on Benefits Key Terms Explained.