The information in this brochure is a general outline of the benefits offered under the City of El Cerrito’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.

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

NEW! See page 24 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 18 for more details.
# Contact Information

<table>
<thead>
<tr>
<th>Plan</th>
<th>Phone Number</th>
<th>Web Site</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Kaiser Permanente</td>
<td>800.464.4000</td>
<td><a href="http://www.kp.org">www.kp.org</a></td>
</tr>
<tr>
<td>• Sutter Health Plus</td>
<td>855.315.5800</td>
<td><a href="http://www.sutterhealthplus.org">www.sutterhealthplus.org</a></td>
</tr>
<tr>
<td><strong>Dental</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Delta Dental</td>
<td>800.765.6003</td>
<td><a href="http://www.deltadentalins.com">www.deltadentalins.com</a></td>
</tr>
<tr>
<td><strong>Group Life Insurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Voya Financial</td>
<td>800.955.7736</td>
<td><a href="https://www.voya.com/">https://www.voya.com/</a></td>
</tr>
<tr>
<td><strong>Short &amp; Long-Term Disability</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Voya Financial</td>
<td>800.955.7736</td>
<td><a href="https://www.voya.com/">https://www.voya.com/</a></td>
</tr>
<tr>
<td><strong>Employee Assistance Program (EAP)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Claremont</td>
<td>800.834.3733</td>
<td><a href="http://www.claremonteap.com">www.claremonteap.com</a></td>
</tr>
<tr>
<td><strong>Flexible Spending Account (FSA)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Benefit Resource Inc.</td>
<td>800.473.9595</td>
<td><a href="http://www.benefitresource.com">www.benefitresource.com</a></td>
</tr>
<tr>
<td><strong>Retirement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• CalPERS Retirement</td>
<td>888.225.7377</td>
<td><a href="http://www.calpers.ca.gov">www.calpers.ca.gov</a></td>
</tr>
<tr>
<td>• ICMA-RC (Deferred Compensation)</td>
<td>800.669.7400</td>
<td><a href="http://www.icmarc.org">www.icmarc.org</a></td>
</tr>
</tbody>
</table>
Introduction

This Benefit Guide is provided to employees as a comprehensive resource for the City of El Cerrito. This Guide is not intended to be a contract (expressed or implied), nor is it intended to otherwise create any legally enforceable obligation on the part of the City, its agents, or its employees. The purpose of this Guide is to summarize the City’s employee benefits and the policies and procedures regarding these benefits. For the most detailed and up to date information please refer to the appropriate plan document, evidence of coverage booklet, insurance policy, or contract. These documents can be obtained by contacting Human Resources.

Open Enrollment

Open Enrollment is held in October of each year. This is the time you can make changes to your benefits, unless you have an IRS qualifying change of status during the plan year. Please see the Qualifying Events list located on page 4.
Eligibility

Employees
The City of El Cerrito offers Medical, Dental, Group Life/ Accidental Death and Dismemberment, and Disability Insurance to full-time employees and their eligible dependents. The City also offers Flexible Spending Account (FSA) for health care or child care expenses.

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 or 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.

The following dependents are eligible:

- Your eligible dependents include your legal spouse, registered domestic partner, and children up to age 26
- Children include your natural children and/or legally adopted children

Change in Dependent Eligibility
It is the employee’s responsibility to notify Human Resources within 30 days or sooner of a dependent’s change in status that would make the dependent eligible or ineligible for benefit coverage. Some examples of a change in dependent status are birth, death, adoption, or divorce.

Continuation of Coverage for Dependents (COBRA)
While you must drop your ineligible dependent within 30 days of the loss of eligibility, failure to drop your ineligible dependent within 60 days of loss of eligibility will result in a loss of continuation of coverage rights (COBRA) for your dependents.

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

You may experience certain events during the plan year that would allow you to change your or your dependent's medical coverage. If any of the following events occur, you have up to 30 days from the date of the event to elect a change in benefit coverage(s).

- 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.
- If the plan receives a decree, judgment, or court order, including a QMSCSO pertaining to your dependent.
- A significant change in benefit or cost of coverage for you or your spouse/domestic partner.
- Your spouse’s or domestic partner’s employer provides the opportunity to enroll or change benefits during an open enrollment period.

Click here to watch a video on Qualifying Life Events.
Medical

The City pays the full premium at the rate of the lowest cost provider (single, +1, or family). If you have other group insurance coverage, the City offers an in-lieu payment at the lowest cost provider’s single rate with proof of coverage for yourself and your IRS tax dependents. The City of El Cerrito offers its employees the choice between a Kaiser HMO and a Sutter Health Plus HMO.

Health Maintenance Organizations (HMOs)

HMOs allow you to review 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 a portion of covered medical services.

- **Copays** – When you receive medical care, you pay a set dollar amount called 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.

Click here to watch a video on Health Maintenance Organizations (HMO).
# Medical: Schedule of Benefits

<table>
<thead>
<tr>
<th>Benefit Categories</th>
<th>Kaiser Permanente</th>
<th>Sutter Health Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Plan Information</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Annual Deductible/Individual</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>• Annual Deductible/Family</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>• Office Visit/Exam</td>
<td>$10 copay</td>
<td>$10 copay</td>
</tr>
<tr>
<td>• Annual Out-of-Pocket Limit/Individual</td>
<td>$1,500</td>
<td>$1,000</td>
</tr>
<tr>
<td>• Annual Out-of-Pocket Limit/Family</td>
<td>$3,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>• Lifetime Plan Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>• Primary Care Physician Election Required</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Well-Child Care</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• Immunizations</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• Well Woman Exams</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• Mammograms</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• Adult Periodic Exams with Preventive Tests</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• Diagnostic X-Ray and Lab Tests</td>
<td>100%</td>
<td>100% preventive; $10 copay lab non-preventive; No charge x-ray non-preventive</td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pregnancy and Maternity Care (Pre-Natal Care)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Hospitalization</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• Pre-Authorization of Services Required</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>• Semi-Private Room &amp; Board; Including Services and Supplies</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Surgical Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient Facility Charge</td>
<td>$10 copay per procedure</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Emergency Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Emergency Room</td>
<td>$10 copay</td>
<td>$50 copay (waived if admitted)</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Air</td>
<td>100%</td>
<td>$50 copay per trip</td>
</tr>
<tr>
<td>• Ground</td>
<td>100%</td>
<td>$50 copay per trip</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Urgent Care Facility</td>
<td>$10 copay</td>
<td>$10 copay</td>
</tr>
<tr>
<td><strong>Mental Health Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Care</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• Outpatient Care</td>
<td>$10 copay per visit for individual; $5 copay per visit for group</td>
<td>$10 copay per visit for individual; $5 copay per visit for group</td>
</tr>
</tbody>
</table>

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.
## Medical: Schedule of Benefits (continued)

<table>
<thead>
<tr>
<th>Benefit Categories</th>
<th>Schedule of Benefits</th>
<th>Kaiser Permanente</th>
<th>Sutter Health Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Substance Abuse</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Care</td>
<td></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>– Inpatient Hospitalization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Inpatient Detoxification Services</td>
<td></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• Outpatient Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Outpatient Services</td>
<td></td>
<td>$10 copay per visit for individual; $5 copay per visit for group</td>
<td>$10 copay per visit for individual; $5 copay per visit for group</td>
</tr>
<tr>
<td><strong>Prescription Drug Benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Generic</td>
<td></td>
<td>$10 copay</td>
<td>$5 copay</td>
</tr>
<tr>
<td>• Preferred Specialty</td>
<td></td>
<td>$10 copay (30 day supply)</td>
<td>90% (not to exceed $250)</td>
</tr>
<tr>
<td>• Brand (Formulary/Preferred)</td>
<td></td>
<td>$10 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td>• Brand (Non-Formulary/Non-preferred)</td>
<td></td>
<td>$10 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td>• Number of Days Supply</td>
<td></td>
<td>100 days</td>
<td>30 days</td>
</tr>
<tr>
<td><strong>Mail Order</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Generic</td>
<td></td>
<td>$10 copay</td>
<td>$10 copay</td>
</tr>
<tr>
<td>• Brand (Formulary/Preferred)</td>
<td></td>
<td>$10 copay</td>
<td>$40 copay</td>
</tr>
<tr>
<td>• Brand (Non-Formulary/Non-preferred)</td>
<td></td>
<td>$10 copay</td>
<td>$80 copay</td>
</tr>
<tr>
<td>• Number of Days Supply for Mail Order</td>
<td></td>
<td>100 days</td>
<td>100 days</td>
</tr>
<tr>
<td><strong>Other Services and Supplies</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Durable Medical Equipment &amp; Prosthetic Devices</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>• Home Health Care</td>
<td>100% part-time intermittent care; 5 visits/day, 100 visits/year</td>
<td>100%</td>
<td>100% calendar year</td>
</tr>
<tr>
<td>• Skilled Nursing or Extended Care Facility</td>
<td>100%; 100 days/benefit period</td>
<td>(prior authorization required)</td>
<td>100%; 100 visits/benefit period</td>
</tr>
<tr>
<td>• Hospice Care</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>• Chiropractic Services</td>
<td>$10 copay; 30 visits</td>
<td>$10 copay; 20 visits</td>
<td>$10 copay; 20 visits</td>
</tr>
<tr>
<td>• Acupuncture</td>
<td>$10 copay (referral required)</td>
<td>$10 copay</td>
<td>(typically provided only for the treatment of nausea or as part of comprehensive pain management)</td>
</tr>
<tr>
<td>• Infertility</td>
<td></td>
<td>Covered; See plan certificate</td>
<td>Covered; See plan certificate</td>
</tr>
<tr>
<td>• Diagnosis</td>
<td></td>
<td>Covered; See plan certificate</td>
<td>Covered; See plan certificate</td>
</tr>
<tr>
<td>• Treatment</td>
<td></td>
<td>Covered; See plan certificate</td>
<td>Covered; See plan certificate</td>
</tr>
<tr>
<td><strong>Outpatient Rehabilitative Therapy Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physical</td>
<td></td>
<td>$10 copay</td>
<td>100%</td>
</tr>
<tr>
<td>• Occupational</td>
<td></td>
<td>$10 copay</td>
<td>100%</td>
</tr>
<tr>
<td>• Speech</td>
<td></td>
<td>$10 copay</td>
<td>100%</td>
</tr>
</tbody>
</table>

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When it comes to a dental plan, you want benefits that fit the needs of you and your family. Delta Dental PPO offers comprehensive dental coverage, quality care and excellent customer service.

**Delta Dental PPO**

Delta Dental PPO, our preferred provider organization (PPO) plan, provides access to the largest PPO Dentist network in the U.S. With this plan, you can access Dentists in both the PPO and Premier Networks (In-Network Dentists) for the lowest out-of-pocket costs. Dentists in these networks agree to accept reduced fees for the covered procedures when treating PPO patients. Because PPO Dentists have agreed to lower fees your out-of-pocket costs are usually lower when you visit a PPO Dentist than when you visit a non-Delta Dental Dentist. You will see more discounts in the PPO network than in the Premier Network, but you have the freedom to visit any licensed Dentist, anywhere in the world.

This matrix is a brief summary of your benefits. You must read the entire evidence of coverage in order to understand the details of your dental coverage.

<table>
<thead>
<tr>
<th>Dental Service</th>
<th>PPO Dentist Delta Dental’s Co-Payment</th>
<th>Non-PPO Dentist Delta Dental’s Co-Payment</th>
<th>Waiting Period</th>
<th>Calendar Year Maximum</th>
<th>Calendar Year Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic and Preventive Services</td>
<td>100%</td>
<td>100%</td>
<td>None</td>
<td>$1,500 for each Enrollee</td>
<td>There is no Deductible requirement</td>
</tr>
<tr>
<td>Basic Services</td>
<td>90%</td>
<td>80%</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crowns, Inlays, Onlays and Cast Restorations</td>
<td>70%</td>
<td>70%</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthodontic Services</td>
<td>50%</td>
<td>50%</td>
<td>None</td>
<td></td>
<td>$2,500 lifetime Maximum for each Enrollee</td>
</tr>
<tr>
<td>Orthodontic Services for adults &amp; children</td>
<td>50%</td>
<td>50%</td>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For more information on Delta Dental please visit [www.deltadentalins.com](http://www.deltadentalins.com).


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**Basic Life/AD&D, STD and LTD**

The City offers Life and Accidental Death & Dismemberment (AD&D), Short Term Disability (STD) and Long Term Disability (LTD) to eligible employees. This benefit is offered through Voya Financial.

**Basic Life and AD&D:**
- 1 x annual earnings to $10,000 minimum; $100,000 maximum

**Short-Term Disability**
- **Benefit waiting period:** 29 days (non-sworn), 59 days (sworn); 2/3 of salary to a maximum weekly benefit of $2,310

**Long-Term Disability:**
- **Benefit waiting period:** 90 days (all full-time employees); 2/3 of salary to a maximum monthly benefit of $10,000

**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.
Employee Assistance Program (EAP)

This program is offered by the City of El Cerrito 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.
Retirement

The City of El Cerrito pays into the California Public Employees’ Retirement System (CalPERS). All full-time and permanent part-time employees must make retirement contributions through bi-weekly payroll deductions. Rates of contributions are based on the employees’ represented unit.

- Retirement benefit amounts are calculated using the employee’s service credit, benefit factor and final compensation.

The current retirement formulas for miscellaneous (non-sworn) employees are:

- **Tier One (Classic Members):** Classic Formula 2.7% @ age 55; final compensation will be based on any 12 highest consecutive months.
- **Tier Two (PEPRA – new hires as of January 1, 2013):** New Formula 2% @ age 62; final compensation will be based on the average of 3 consecutive years prior to retirement date.

The current retirement formulas for safety (sworn) employees are:

- **Tier One (Classic Members):** Classic Formula 3% @ age 50; final compensation will be based on any 12 highest consecutive months.
- **Tier Two (PEPRA – new hires as of January 1, 2013):** New Formula 2.7% @ age 57; final compensation will be based on the average of 3 consecutive years prior to retirement date.

Retirement provisions for all employees include the following:

- An employee becomes vested in retirement system after 5 years of service.
- Employees in Tier One are eligible to retire as early as age 50. Employees in Tier Two are eligible to retire at age 52. Early retirement is subject to proration of retirement rates stated above.
- The employee pays the required employee contribution portion. This amount is deducted from your paycheck. The funds paid by the employee go into an account and earn interest. If you separate from employment for reasons other than retirement, you are entitled to withdraw these funds or if vested, leave them in the account and defer retirement.
- Employees who have service credit with other CalPERS agencies or have service in a reciprocal member agency will receive retirement benefits for those years based on the respective agency’s retirement formula and final compensation.
- Retirees may receive a cost of living adjustment up to 2% per year.
- Employees retiring from the City of El Cerrito are entitled to automatically continue their medical coverage with the City of El Cerrito at the employee’s expense. This benefit is subject to the employee’s Memorandum of Understanding (MOU).
- Employees interested in learning more about their retirement may contact CalPERS directly at 888.225.7377 or visit the CalPERS website at calpers.ca.gov. Alternatively, employees may also contact the City of El Cerrito’s Human Resources Department at 510.215.4315.

Deferred Compensation and Roth IRA

Full-time and permanent part-time employees can elect to participate in a voluntary 457 (b) retirement plan or a Roth IRA through ICMA-RC. The 457(b) reduces the employee’s taxable income while providing savings for retirement. The benefits of a Roth IRA are that your contributions can grow tax-free and you can generally make withdrawals tax-and penalty-free after you reach age 59 ½. 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 to either a 457 (b) plan or a Roth IRA.
Flexible Spending Accounts

Flexible Spending Accounts are a great cost savings tool to help with common medical and/or dependent care expenses not covered by your insurance. You can elect a portion of your pay to be deducted, on a pre-tax basis, from each paycheck to use for reimbursements of qualified out-of-pocket expenses throughout the plan year.

Health Flexible Spending Account (FSA)

A Health Flexible Spending Account (FSA) allows you to allocate money on a pre-tax basis to reimburse yourself for qualified medical expenses for you and your family. Qualified expenses include copays, medical deductibles, prescriptions and much more. This does not include premium payments.

The Maximum amount you may contribute to your FSA account in 2023 is $3,050.

Partial List of Eligible Expenses (for a complete list of eligible expenses, please visit www.benefitresource.com)

- Copays / coinsurance
- Deductibles
- Dental treatments
- Diabetic supplies
- Prescription drugs and medicines
- Eye exams, eyeglasses, contact lenses, contact lens solution and enzyme
- Flu shots
- Immunizations
- Lab fees
- Laser / Lasik / RK surgery
- Medical exams
- Orthodontia
- Psychiatric care
- Wheelchair
- X-rays

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

A Dependent Care Account allows you to allocate money on a pre-tax basis to reimburse yourself for dependent care services such as after school care and dependent daycare centers.

The minimum amount you may contribute to a Dependent Care Account for the plan year is $250; the maximum is $5,000.

Partial List of Eligible Expenses (for a complete list of eligible expenses, please visit www.benefitresource.com)

- After-school care or extended day programs
- Nanny expenses
- Baby-sitter inside or outside participant's household
- Custodial or elder care expenses if the qualifying individual still spends at least eight (8) hours each day in the employee's household
- Dependent care center expenses / pre-kindergarten / nursery school expense if primary purpose is to care for the child so the parent can work
- Expenses paid to a non-dependent relative of participant
- Summer day camp if the primary purpose of the expense is custodial in nature and not educational (excluding overnight facilities)

Regardless of whether you participate in the dependent care plan under Section 125 or claim the credit on your income tax, you must provide the IRS with the name, address and taxpayer identification number (TIN) or Social Security number of your dependent care provider(s) by completing either Schedule 2 of Form 1040A or Form 2441 and attaching it to your annual income tax return. Be sure that you follow the current instructions given by the IRS for preparing your annual income tax return. Failure to provide this information to the IRS could result in loss of the pre-tax exemption for your dependent care expenses.

FSA Fund Availability

Health FSA Account

Your full annual election is available to you on January 1st of the plan year.

Dependent Care Account

Unlike the Health FSA, the entire elected amount is not available on the first day of the plan year, but rather as contributions are received and services have been provided.

Important FSA Notes

If you are a new employee entering the plan during a plan year, services must be provided after you are eligible to participate in the plan.

If you are enrolled in the Health FSA and take a leave of absence during the plan year, you may:

1. Prepay the contributions pre-tax, or
2. Continue the contributions on an after-tax basis (pre-tax contributions may continue when you return to work), or
3. Prorate the unpaid contributions over the remaining pay periods when you return to work.

Failure to make all elected contributions will result in termination of your account as of the date contributions ceased.

You may roll over up to $610 per year in unused funds.

* A Dependent Care Center is a place that provides care for more than six persons (other than persons who live there) and receives a fee, payment or grant for providing services for any of those persons, regardless of whether the center is run for profit.
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 El Cerrito 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 El Cerrito 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 510.215.4315 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 medical 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 medical carrier.

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

COBRA Continuation Coverage
This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under 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.

**H OW 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](http://www.healthcare.gov).
ENROLLMENT IN MEDICARE INSTEAD OF COBRA
In general, if you don’t enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period 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.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES
To protect your family’s rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

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

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

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

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

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

1 https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods
Important Notices (continued)

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:

Shannon Bassi
510.215.4315

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 El Cerrito and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare’s prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

- The City of El Cerrito has determined that the prescription drug coverage offered by the City of El Cerrito Medical Plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?
If you decide to join a Medicare drug plan, your current City of El Cerrito coverage will not be affected. If you keep this coverage and elect Medicare, the City of El Cerrito coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current City of El Cerrito 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 El Cerrito 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 consistantly 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 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).

Name of Entity / Sender: City of El Cerrito
Contact: Shannon Bassi
Address: 10890 San Pablo Avenue
El Cerrito, CA 94530
Phone: 510.215.4315

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices
The City of El Cerrito 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 Shannon Bassi, 510.215.4315 or jobs@ci.el-cerrito.ca.us
Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about the City of El Cerrito 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.

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<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
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<tbody>
<tr>
<td>City of El Cerrito</td>
<td>94-6000325</td>
</tr>
<tr>
<td>5. Employer address</td>
<td>6. Employer phone number</td>
</tr>
<tr>
<td>10890 San Pablo Avenue</td>
<td>510.215.4315</td>
</tr>
<tr>
<td>7. City</td>
<td>8. State</td>
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<tr>
<td>El Cerrito</td>
<td>CA</td>
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<tr>
<td>9. ZIP code</td>
<td>10. Who can we contact about employee health coverage at this job?</td>
</tr>
<tr>
<td>94530</td>
<td>Shannon Bassi</td>
</tr>
<tr>
<td>11. Phone number (if different from above)</td>
<td>12. Email address</td>
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<tr>
<td></td>
<td><a href="mailto:jobs@ci.el-cerrito.ca.us">jobs@ci.el-cerrito.ca.us</a></td>
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</table>

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.
Important Notices (continued)

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

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

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility.

**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
CHIP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
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
Phone: 678-564-1162, press 2

**INDIANA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssai/hip/
Phone: 877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 800-457-4584

**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
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/iahipp
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
Phone: 800-977-6470 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/health-insurance-premium-program
Phone: 800-871-0710
HIPP Program Toll-Free Phone: 800-852-3345, ext. 5218

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.health.ny.gov/medicaid/premium
Phone: 603-271-5218

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/medicaid/premium
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
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
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: 803-734-2000

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).
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.