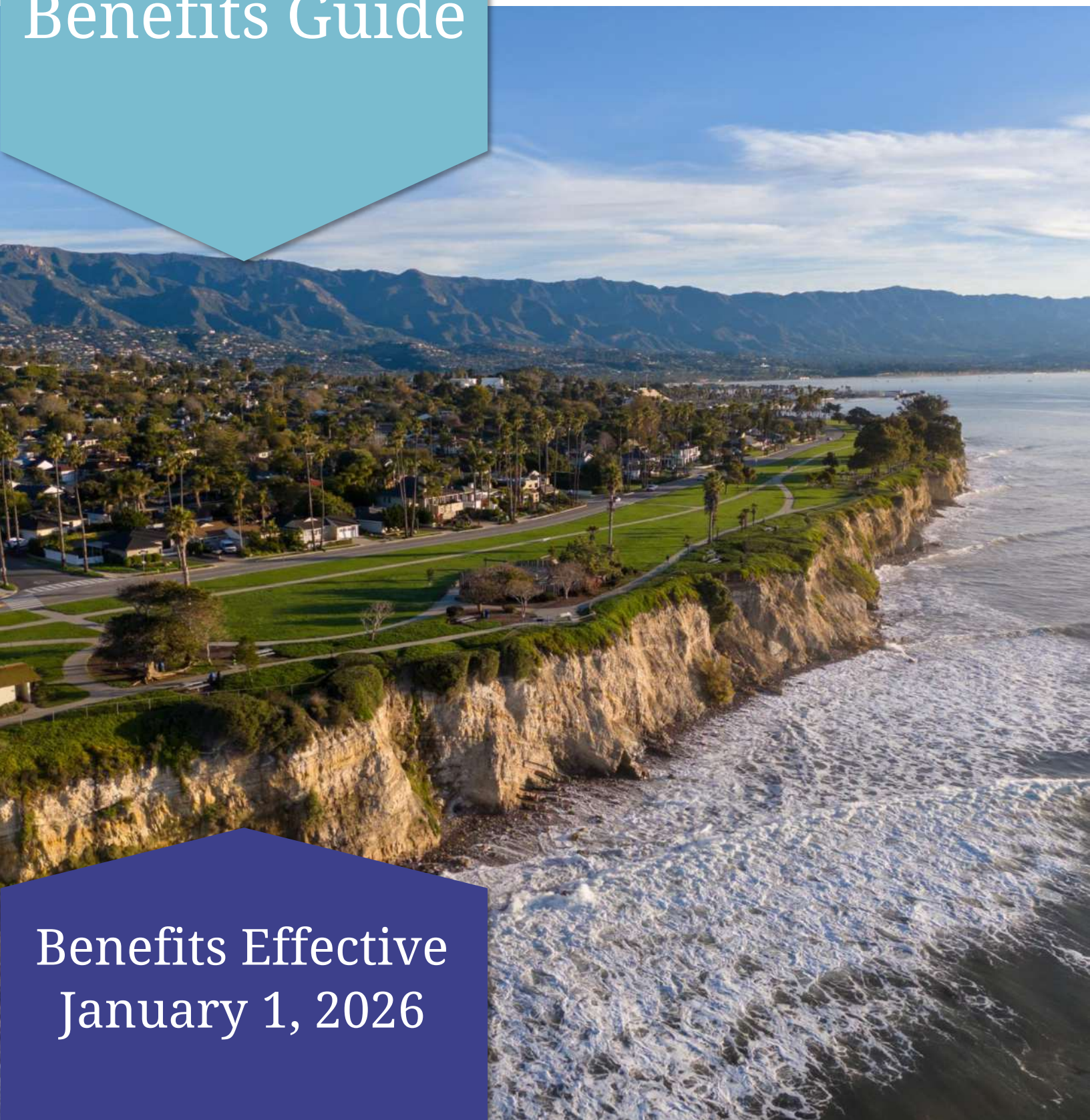
2026 Employee Benefits Guide

KEEP THIS BENEFITS BOOKLET FOR YOUR REFERENCE NEEDS THROUGHOUT THE YEAR



Benefits Effective January 1, 2026

Inside the Guide

This brochure summarizes the benefit plans that are available to eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Benefits Office. Information provided in this brochure is not a guarantee of benefits.

Welcome

City of Santa Barbara recognizes that benefits are an important part of your total compensation and the well-being of you and your covered dependents. Each year we work with our providers to carefully review our benefits program, search for new ways to maintain the quality of our plans and meet the benefit needs of you and your family in a cost-effective manner. This brochure is a guide to the options available for the duration of the plan year. The actual plan documents shall prevail in case of any conflict in descriptions.

Selecting your benefits can be confusing. As a healthcare consumer, it's very important that you educate yourself about the various health plans being offered. In doing this, you should consider the costs, benefits, ease of obtaining healthcare, and how well the plan matches the needs of you and your family.

If you have further questions about the information contained in this brochure or about any of the benefit options, please don't hesitate to call the Benefits Office.

Eligibility

Employees

All full-time and part-time regular employees (working at least 40 hours or more biweekly) are eligible to enroll in the City-sponsored group health plans.

If you are a newly hired employee, you are eligible for benefits on the first day of the month following your date of hire. Your eligible dependents are also eligible at that time.

At the time of new hire, you will be provided enrollment materials for electing your benefit plans. You must enroll within 60 days from your hire date. Your subsequent benefit election changes may be made during the next annual Open Enrollment period.

Choose your coverage carefully as your plan elections are irrevocable until the next annual Open Enrollment period or unless you have a qualifying event. Refer to the Rules for Benefit Changes During the Year listed on the following page.

Eligible Dependents

You may enroll your eligible dependents in the benefit plans if you enroll yourself. Eligible dependents include your:

- Legal spouse or state-registered domestic partner, (in the event of marriage or certification of a registered domestic partnership, you are required to provide a copy of the marriage license or domestic partner certification to the Benefits Office within 60 days of the event)
- Children to age 26 for medical, dental, and vision coverage (including stepchildren, legally adopted children, children placed for adoption, and children of registered domestic partners)
- Dependent children if physically and mentally unable to care for themselves with the physical or mental incapacity occurring prior to their 26th birth date
- Grandchildren are not eligible dependents unless you are their legal guardian.

If you have a dependent who is moving away from home, you will need to contact the Benefits Office (see page 32) within 60 days of the move to determine which plan is available for that dependent.

If you or a dependent has a change of address, you will need to contact the Benefits Office (see back cover) within 60 days of the change to confirm benefit plan eligibility for the area.

If your enrolled dependent becomes ineligible for coverage, (Note: this includes a divorce, dissolution of a domestic partnership, or child(ren) no longer dependent(s) as defined above), you will need to contact the Benefits Office (see back cover) within 60 days of the event in order for your enrolled dependent to be terminated from coverage. In the event of divorce or dissolution of a registered domestic partnership, you are required to provide a copy of the divorce order or domestic partnership termination to the Benefits Office within 60 days of the event.

The City may request that you submit documentation of your dependents as proof of eligibility for coverage. You will be responsible for benefit claims paid by the health plans and City-paid premium costs for any enrolled ineligible dependent(s).

Enrollment

When to Enroll

During Open Enrollment — During the City's annual Open Enrollment period you can make changes to your benefit plans, select new benefit plans, and add or delete eligible dependents. The annual Open Enrollment period is typically in the Fall each year for plan year coverage effective January 1st.

As a new hire — If you choose to enroll in our benefits package, as a new hire, you will have the opportunity to do so within your first 60 days of employment.

How do I make changes during the year?

Changes to your benefits can only be made during Open Enrollment or if you experience a Qualified Life Event. The City's benefit plan year begins each January 1st and ends December 31st. Benefit plans and rates are established each plan year.

Choose your coverage carefully, as your plan elections are irrevocable until the City's next annual Open Enrollment period. Refer to the rules for mid-year qualified status change on the following page that would permit enrollment changes during the plan year.

When Coverage Ends

Your City provided group health coverage terminates the last day of the month in which you separate from City employment. If you leave employment with the City, or you or any of your covered dependents are no longer eligible to participate in the City's health plans, continuation of coverage under the law called Consolidated Omnibus Budget Reconciliation Act, or COBRA, is available.

Pre-existing medical conditions

By law, you cannot be denied coverage for pre-existing conditions.

Premiums

Your premium rates for coverage depend on the plan options you choose and the number of covered dependents. Monthly premium rates are included on your Benefits Enrollment Worksheet and the Benefits SharePoint website. Refer to your Benefits Enrollment Worksheet for the City and employee portions of the plan costs.

Quick Tip

The City of Santa Barbara offers eligible employees a comprehensive benefits program including a variety of quality health plans and coverage options to promote good health, peace of mind and financial security through CalPERS for benefited employees.

You are encouraged to use this Guide as a reference throughout the year. If you have questions, contact the Benefits Office.

Choosing a health coverage option is an important decision. To help you make an informed selection, the insurance carriers make available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format.

The SBCs are available on the City's Benefits website. A paper copy is also available at no cost by calling the Benefits Office.

Contributions

Your contributions towards your coverage (if any) are required and will be deducted from your paycheck on a pre-tax basis, which means you never pay federal or state taxes on the income used to pay your contributions. You will receive 26 paychecks for the year. Payroll deductions for any required contributions are taken on 24 paychecks for the year. For the third paycheck received for the month of May and October 2026, no payroll deductions will be taken. Every effort is made to ensure deduction amounts are accurate, but it is ultimately the employee's responsibility to review each pay stub and notify the Benefits Office of any discrepancies. If a payroll discrepancy is identified, an adjustment is required for any reimbursement to you or the City

Rules for Benefit Changes During the Year

Choose your coverage carefully. The coverage you choose at Open Enrollment and the dependents you cover cannot be changed until the next annual Open Enrollment period unless you have a qualified status change. Refer to page 25 for the description of the Qualified Status Changes for the allowed benefit plan option changes due to status changes. Please note that CalPERS Health has different rules for plan changes during the year. It is recommended you review the CalPERS Health Program Guide for additional information. The following is a partial list of qualified status changes:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, or death of a spouse
- Registration of state Domestic Partnerships or termination of state or local Domestic Partnerships
- Change in number of dependents, including birth, adoption, or death of a dependent child
- Change in employment status that affects eligibility for benefits, including the start or termination of employment by you, your spouse, or your child
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your child, including a switch from part-time to full-time employment that affects eligibility for benefits
- Change of residence, including a change that affects the accessibility of network providers
- Change in eligibility of a child, including a child reaching the age of 26
- Change in your coverage or your spouse's coverage due to your spouse's or child's employment
- Change in dependent coverage due to a court order resulting from a divorce, legal separation, annulment, or change in legal custody requiring coverage for a dependent child

You must report the qualified status change to the Benefits Office within 60 days of the event date (e.g., marriage, birth, change in employment status of your spouse or child, etc.). With proof of a qualified status change, your health benefits changes must be consistent with the qualified status change.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other medical insurance coverage, you may in the future be able to enroll yourself or your dependents in the City group plans, provided that you request enrollment within 60 days of your other coverage ending. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents, provided that you request enrollment within 60 days of the marriage, birth, adoption, or placement for adoption.

If you or a family member loses coverage under Medicaid or the state children's health insurance program, you may be able to enroll yourself and your dependents, provided that you request enrollment within 60 days of the loss of coverage date.

CalPERS Medical

The City contracts with CalPERS for medical coverage. All permanent full-time and part-time active employees are eligible for City-sponsored group health benefits and must either enroll in a City-sponsored medical plan, or sign the Employee Waiver Form, and provide proof of their minimum essential coverage under another group medical plan through a spouse, domestic partner, parent, or programs such as Tricare, Medicare, or Medi-Cal. Please note that individual medical coverage through an individual health plan or Covered California will not be accepted as proof of other coverage. If proof of minimum essential coverage under another group medical plan is provided to the Benefits Office, employees may waive the City-sponsored group medical coverage (see section below). If no enrollment is made by an eligible employee, or proof of another group medical coverage is not provided to the Benefits Office, employees will be enrolled in the PERS Platinum PPO medical plan at the Employee-Only coverage.

Because everyone has different health care needs and preferences, the City offers you a choice of medical plan options designed to meet your health care needs. The CalPERS Health Benefit Summary Booklet provides an overview of the HMO and PPO plans. The medical coverage summaries are not comprehensive. If your medical coverage-related questions are not addressed in the coverage summaries, contact the Benefits Office for assistance.

Here are some guidelines to consider when choosing a plan.

HMO	PPO
Members must select a Primary Care Physician (PCP) from the carrier network. PCP will refer to specialists within the same medical group or physician group. PCP will also take care of prior authorizations when needed. Hospitalization will be at the facility where the physician has admitting rights. Benefits are not available out-of-network unless it is an emergency. Services typically require a small dollar co-payment and there are no claims to file unless it is an emergency claim.	Members do not need to select a Primary Care Physician (PCP) and may self-refer to a specialist. The most financial savings in costs are from PPO providers. Members can use Non-PPO providers but keep in mind members will incur more out-of-pocket costs. Members are responsible for making sure prior authorizations are obtained. Costs are in the form of a co-insurance percentage after satisfying a deductible for most services. Claims submission is required for services provided by a Non-PPO provider.

HMO Options	PPO Options
Anthem Select HMO	PERS Gold PPO
Anthem Traditional HMO	PERS Platinum PPO
Blue Shield Trio HMO	PORAC – only for safety employees
Blue Shield Access+ HMO	
Health Net Salud y Mas	
Kaiser Permanente HMO	
United Healthcare SignatureValue Alliance HMO	
United Healthcare SignatureValue Harmony HMO	

Important Update:

Effective January 1, 2026: CVS Caremark (CVS) will replace OptumRx as the new pharmacy benefits manager (PBM).

Not all health plans will be affected by this change. For more information on changes visit CVS Caremark Pharmacy Benefits.

You've Got Choices

Live/ Work Criteria When Selecting a Medical Plan

You may enroll in a plan using either your residential or work zip code. When you become an Annuitant and are no longer working for any employer, you must select a health plan using your residential zip code.

When you use your work zip code, all enrolled dependents must receive all covered services (except emergency and urgent care) within the plan's service area, even if they do not reside in that area.

Do CalPERS Medical Plans Meet the Affordable Care Act Standards?

All CalPERS medical plans offered by the City of Santa Barbara provide Minimum Essential Coverage and meet the Minimum Value Standards.

Click the following for health care terminology: https://www.healthcare.gov/sbc-glossary/. When the link opens, click on the "x" to bypass adding your state and email address. This is a valuable resource to reference as you review your benefit options.

Where Can I Find CalPERS Information Customized for Me?

Employees should always login to CalPERS.ca.gov and PORAC (for safety members only) for the most current CalPERS information, including rate and benefit information.

2026 CalPERS Health Maintenance Organization (HMO) Plan Changes

Basic HMO Plans will be expanding into neighboring counties. The Blue Shield Trio will be exiting Monterey County and will be replaced by Blue Shield Access+. Please visit CalPERS website for more information: CalPERS Changes

2026 CalPERS Preferred Provider Organization (PPO) Plan Changes

For members in the PERS Gold PPO plan options: they will continue with in-patient deductible credits of up to $500 for completing an expanded menu of preventive care activities such as cancer screenings, vaccinations, depression screening, or participation in a Diabetes Prevention Program (if applicable).

You may waive your medical coverage

If you have minimum essential coverage under another group medical plan through a spouse, registered domestic partner, parent, or programs such as Tricare, Medicare or Medi-Cal, you have the option to waive medical coverage for yourself and your expected tax family (as defined in the Employee Waiver Form). To waive medical coverage, you must provide information regarding your other group coverage when making your annual online Open Enrollment election, and you must provide proof of other group medical coverage to the Benefits Office. **IMPORTANT NOTE: Coverage from the individual market, including Covered California, is NOT valid for waiving the City's Medical plan. Please contact the Benefits Office for additional details.**

In the event your coverage under another plan terminates, or if there is a change to your other group medical coverage during the year, you are required to provide notice to the Benefits Office within 60 days of the event date. If your coverage is terminated under another plan within 60 days of the event date, you are required to enroll in a City-sponsored medical plan of your choice.

HMO Medical Plan Benefits

The City of Santa Barbara offers HMO medical plans through **CalPERS** to their benefit-eligible employees. You must obtain health care services from **In-Network** providers and facilities. Services not obtained from network providers or facilities will not be covered, except in qualifying emergency situations or if referred by a network physician.

Copayments shown reflect your responsibility	HMO Options
Calendar Year Deductible & Out-of-Pocket Maximum	**Anthem Blue Cross, Blue Shield, Kaiser Permanente, UHC**
Deductible	None
Out-of-Pocket Maximum	$1,500 Individual / $3,000 Family
Physician Office Visit	
Primary Care / Specialist Care	PCP/SPC: $15 copayment; Trio SPC: $30 copay
Preventive Care	No Charge
Telehealth Visits	No Charge
Diagnostic Services	
X-ray and Lab Tests	No Charge
Complex Radiology	No Charge
Emergency Services and Hospitalization	
Urgent Care Facility	$15 copayment
Emergency Room (waived if admitted)	$50 copayment/visit
Inpatient Hospitalization	No Charge
Outpatient Surgery	Kaiser: $15 copayment; Other HMO Carriers: No Charge
Mental Health and Substance Abuse	
Inpatient	No Charge
Outpatient	$15 copayment for Office Visit; Other No Charge
Other Services (Chiropractic / Acupuncture combined 20 visits per year)	
Chiropractic	$15 copayment
Acupuncture	$15 copayment
Retail Pharmacy (up to 30-Day Supply)	
Tier 1	$5 copayment
Tier 2	$20 copayment
Tier 3	$50 copayment
Tier 4	Blue Shield: $30 copayment; Kaiser: $20 copayment; UHC: N/A; Others: Follow tier structure
Mail Order Pharmacy (up to 90-Day Supply); $1,000 maximum copay per person per year except for Kaiser.	
Tier 1	$10 copayment
Tier 2	$40 copayment
Tier 3	$100 copayment
Tier 4	Blue Shield: $60 copayment; Anthem: Follow tier structure; Others: N/A

For more details about the benefits provided by the medical plans, refer to their SBCs and evidence of coverage (EOC) booklets.

PPO Medical Plan Benefits

The City of Santa Barbara offers PPO medical plans through **CalPERS** to their benefit-eligible employees. You may obtain health care services from **In-Network (PPO) or Out-of-Network** providers and facilities. Services not obtained from in-network providers or facilities will be covered at a lesser amount.

Deductible, copayment, and coinsurance amounts shown reflect your responsibility	Blue Shield PPO Gold (Only available in CA)	Blue Shield PPO Platinum	PORAC
Calendar Year Deductible & Out-of-Pocket Maximum			
Deductible	$1,000[1] Individual / $2,000 Family	$500 Individual / $1,000 Family	$300 Individual / $900 Family
Out-of-Pocket Coinsurance Maximum (excluding pharmacy)	$3,000 Individual / $6,000 Family	$2,000 Individual / $4,000 Family	$2,000 Individual / $4,000 Family
Physician Office Visit			
Primary / Specialist Care	$10 copayment / $35 copayment	$20 copayment / $35 copayment	$10 copayment / $35 copayment
Preventive Care	No Charge	No Charge	No Charge
Telehealth Visits	No Charge	No Charge	No Charge
Diagnostic Services			
X-ray and Lab Tests	20% after deductible	10% after deductible	20% after deductible
Complex Radiology	20% after deductible	10% after deductible	20% after deductible
Emergency Services and Hospitalization			
Urgent Care Facility	$35 copayment	$35 copayment	$35 copayment
Emergency Room (copay waived if admitted)	$50 / visit + 20% after deductible	$50 / visit + 10% after ded.	20% after deductible
Inpatient Hospitalization	20% after deductible	$250 per admit + 10% after ded.	20% after deductible
Outpatient Surgery	20% after deductible	10% after deductible	20% after deductible
Mental Health and Substance Abuse			
Inpatient	20% after deductible	$250 per admit + 10% after ded.	20% after deductible
Outpatient	$35 copayment	$20 copayment	20% after deductible
Other Services (Chiropractic/ Acupuncture combined 20 visits/ year)			
Chiropractic	$15 copayment	$15 copayment	20%
Acupuncture	$15 copayment	$15 copayment	20%
Retail Pharmacy (Up to 30-Day Supply)			
Tier 1	$5 copayment	$5 copayment	$10 copayment
Tier 2	$20 copayment	$20 copayment	$25 copayment
Tier 3	$50 copayment	$50 copayment	$45 copayment
Mail Order Pharmacy (up to 90-Day Supply) $1,000[2] maximum out of pocket copay limit per person per year for PERS Gold and PERS Platinum; $2,000 maximum out of pocket limit per person per year for PORAC)			
Tier 1	$10 copayment	$10 copayment	$20 copayment
Tier 2	$40 copayment	$40 copayment	$40 copayment
Tier 3	$100 copayment	$100 copayment	$75 copayment

*The out-of-network benefits for the PPO plans can be found on the SBCs and Evidence of Coverage booklets.

[1] PERS Gold: There are two separate $500 deductibles: one for inpatient care and one for outpatient care. Please note that you can't use one deductible to satisfy the other. Each deductible must be met separately.

[2] The $1,000 maximum copay limit applies to Tiers 1 & 2 maintenance medications through CVS Caremark for PERS Gold and PERS Platinum.

For more details about the benefits provided by the medical plans, refer to their SBCs and evidence of coverage booklets.

Flexible Spending Accounts

WEX will continue to administer the flexible spending accounts for the City. Flexible Spending Accounts (FSAs) allow you to pay for certain eligible expenses with income that you have contributed to a personal reimbursement account on both a federal and state pretax basis. This saves you tax dollars. There are two types of FSA accounts: Health Care Spending Account and Dependent Care Spending Account.

During Open Enrollment, you decide how much you want to contribute during the plan year (January 1 through December 31) to either or both accounts based on your estimation of annual eligible expenses you will incur that are eligible for reimbursement. You are reimbursed from your account for your costs of eligible expenses from claims you file with the plan administrator.

You may contribute a maximum of up to $3,300 per year to the Health Care Spending Account, and up to $7,500 per year per household to the Dependent Care Spending Account (for up to $3,750 if you are married and file separate tax returns). The minimum contribution to each account is $240 per year. Your FSA contributions are deducted in equal amounts during the plan year over 24 paychecks. (For the third paychecks in the months of May and October 2026, you will not have FSA contributions taken.)

Because of the tax-favored features of the FSA, there are very important Internal Revenue Service requirements for FSA participants. Please note:

1. You cannot change your FSA contribution amounts during the plan year unless you have a "qualified status change." (See Qualified Status Changes on page 25).
2. No claims for reimbursement will be accepted after the March 31st claims filing deadline.
3. Funds remaining in your FSA after processing all claims filed by the March 31st deadline will be forfeited. This is called the "use-it-or- lose-it" rule.
4. To contribute to an FSA for 2026, you must elect the FSA and your annual contribution pledge through the online Benefits Enrollment Website. The previous year's FSA will not roll over.
5. IRS rules allow for a grace period of an additional 2 ½ months following the end of each plan year (December 31) to incur and file for eligible expenses against your Health Care and Dependent Care account funds. This annual grace period, from January 1 through March 15, means you have a total of 14 ½ months to incur eligible expenses for reimbursement from your plan year contributions. For example, if you are a current 2025 plan participant, you have a total period from January 1, 2025, through March 15, 2026 (14 ½ months) to incur eligible expenses for reimbursement of your 2025 contributions. To avoid 2025 forfeitures, claims must be filed by the deadline of March 31, 2026.

Remember:

Through payroll deduction, you begin setting pre-tax dollars aside based on your annual election. Equal amounts are deducted each payroll period throughout the year.

- You have immediate access to the full annual elected amount in your Health FSA. You will only be able to access available funds in your Dependent Care FSA, not "future" funds.
- You **cannot** transfer funds between your Health FSA and Dependent Care FSA.

When you incur a qualified Health or Dependent Care expense. You may either:

- Use your FSA Debit Card for the purchase or pay out-of-pocket and submit a claim for reimbursement.

Save your receipts! You may be required to produce them during a plan year audit as required by the IRS.

6. Your health care FSA debit card may be used during the grace period (January 1 – March 15, 2026); funds will come out of your 2025 account first.

7. If you retire or terminate employment and you have remaining FSA account funds, you must elect COBRA FSA coverage for the balance of the plan year in order to remain an FSA plan participant. You must be an FSA plan participant at plan year end in order to continue with the 2 ½ month grace period for incurring expenses and/or filing claims for reimbursement by the deadline.

Estimate your expenses carefully to avoid forfeitures

Eligible Health Care Expenses

Eligible Health Care FSA expenses are those out-of-pocket medical, dental, and vision expenses that are not covered by other insurance plans, such as deductibles, copayment, coinsurance, prescription drugs, and certain other expenses the plans don't cover. As a general rule, an eligible health care expense is an expense that has been incurred by you and/or your eligible dependents that satisfies the following conditions:

a) The expense is for "medical care" as defined by Internal Revenue Code Section 213(d); and

b) The expense has not been reimbursed by any other source and you will not seek reimbursement for the expense from any other source.

The Internal Revenue Code generally defines "medical care" as any amounts incurred to diagnose, treat or prevent a specific medical condition or for purposes of affecting any function or structure of the body. Not every health-related expense you or your eligible dependents incur may be an expense for "medical care." You may be required by the FSA administrator to provide documentation of medical necessity from a healthcare provider.

The Internal Revenue Service (IRS) Publication 502 (Medical and Dental Expenses) lists expenses you can claim on your federal tax return which is generally used as the basis for your Health Care FSA Account reimbursement claims. The Publication 502 is available on the Benefits SharePoint website for your information.

Eligible Dependent Care Expenses

Eligible Dependent Care FSA expenses are those that enable you (or you and your spouse, if you are married) to work or attend school full-time. These expenses include day care, preschool programs and before- and after-school care expenses for qualifying children and qualifying relatives under age 13. Tuition for school-age children is not an eligible expense.

Eligible expenses also include elder care, or care for qualifying dependents and qualifying relatives of any age who are not capable of caring for themselves.

Each dependent for whom you incur expenses must be a qualifying individual, defined as:

- A person under age 13 who meets the definition of a "qualifying child" under Internal Revenue Code §152 (c).
- Your legal spouse or a person who is your dependent under federal tax law, but only if he or she is physically or mentally incapable of self-care.
- A qualifying individual must share the same principal residence as you for more than half the year, and if other than your spouse or certain children, have gross income less than the personal exemption amount under Internal Revenue Code §151(c) for the year.

Reduce Your Tax Dollars

Because FSA contributions are made before federal or state income taxes are withheld, you save money. Consider the example illustrated in the table below. This example assumes that you are married and have one child under the age of 13. You anticipate having $1,200 in eligible medical expenses for the family under the Health Care FSA and $2,400 in dependent care expenses. You earn $45,000 and your spouse has no income. You file a joint tax return.

Plan Carefully Before Enrollment

The Health Care Account and Dependent Care Account function separately. This means you cannot use health care funds to pay dependent care expenses and vice-versa.

When you incur eligible expenses, you submit your claims to the City's Flexible Spending Account administrator to receive a reimbursement. The payment will be made directly to you and you do not pay taxes on the money you receive. You cannot claim a deduction for these expenses on your tax return since you never paid taxes on them.

Be certain to calculate your eligible expenses carefully, as amounts that you contribute to your FSA account, but do not use for eligible expenses incurred during the plan year or grace period, will be forfeited per IRS requirements.

Remember, an IRS rule allows an additional 2 ½ months grace period after the end of the plan year (December 31) to accumulate expenses to file for reimbursement of remaining account funds. For 2025 contributions, the grace period is through March 15, 2026. Claims for reimbursement of 2025 contributions must be filed by the deadline of March 31, 2026. Any remaining plan year 2025 contributions in your FSA account after March 31, 2026 will be forfeited.

	If you participate in the Flexible Spending Account	If you do not participate in the Flexible Spending Account
1. Gross Income	$45,000	$45,000
2. Salary Reductions for FSA Contributions ($104 per paycheck)	($2,500) (pre-tax)	$0
3. Adjusted Gross Income (Line 1 minus Line 2)	$42,500	$45,000
4. Estimated Taxes	($13,119)	($14,131)
5. Income After Taxes	$29,381	$30,869
6. Eligible FSA Expenses	($2,500)	($2,500)
7. FSA Reimbursement	$2,500	$0
8. Net Income After Taxes and Expenses	$29,381	$28,369
9. Savings from FSA	$1,012	$0

Dental Benefits

The City offers a choice of three dental plans. You may choose the Delta DPO Basic or Buy-Up Plan or the DeltaCare HMO Plan.

Delta Dental PPO Base

The Delta DPO Basic Plan, administered by Delta Dental of California, works like a medical PPO plan. It allows you to receive care from any dentist each time you seek care, but you will receive the highest level of benefits at the lowest out-of-pocket cost when you utilize a DPO dentist (ie. PPO dentist).

If you choose an out-of-network dentist who is in the Premier network, you will still receive a discount on charges but not as much as if you were to choose a PPO dentist. If you choose an out-of-network dentist who is not a Delta dentist, you will have to pay the cost difference if your dentist charges are more than Delta's approved fees. This cost will vary by provider and may be significant. You may also have to pay your entire bill in advance and then file a claim for reimbursement.

To locate a network provider, go to www.deltadentalins.com and select ***Find a Provider***. Be sure to select your correct network.

Delta Dental questions?
DPPO members – (800) 765- 6003

Deductible and coinsurance amounts reflect your responsibility.	Delta Dental PPO™ In-Network	Delta Dental Premier™ Out-of-Network*	Non-Delta Out-of-Network*
Calendar Year Deductible and Maximum			
Deductible (Individual / Family)	$50 per person $150 per family	$50 per person $150 per family	$50 per person $150 per family
Maximum per covered person	$1,500 per person	$1,500 per person	$1,500 per person
Services			
Diagnostic & Preventive Oral Exams, Prophylaxis (cleanings), X-rays	Covers 100% of DPO negotiated fee (deductible waived) Does not apply towards maximum annual benefit	Covers 100% of Premier approved fee	Covers 100% of Program allowance
Basic Sealants, Fillings, Extractions, Anesthesia, Endodontics, Periodontics	Covers 100% of DPO negotiated fee	Covers 100% of Premier approved fee	Covers 100% of Program allowance
Major Bridges, Crowns, Dentures	Covers 100% of DPO negotiated fee (dentures subject to maximum allowance)	Covers 100% of Premier approved fee (dentures subject to maximum allowance)	Covers 100% of Program allowance (dentures subject to maximum allowance)
Prosthodontic Care			
Implants	Covers 100% of DPO negotiated fee	Covers 100% of Premier approved fee	Covers 100% of program allowance
Orthodontia Adult and Children	Covers 50% of DPO negotiated fee up to $2,000 lifetime maximum per person	Covers 50% of Premier approved fee up to $2,000 lifetime maximum per person	Covers 50% of Delta program allowance up to $2,000 lifetime maximum per person

*Out-of-Network providers include both Premier dentists and Non-Delta affiliated dentists. Balance-billing will result with Non-Delta affiliated dentists.
For more details about the benefits provided by the dental plans, refer to their evidence of coverage (EOC) booklet.

Delta Dental PPO Buy- Up

The Delta DPO Buy-Up Plan, administered by Delta Dental of California, works just like the Base plan with the difference in the Maximum Annual Benefit for the DPO Network dentists.

Deductible and coinsurance amounts represent member's responsibility.	Delta Dental PPO™ In-Network	Delta Dental Premier™ Out-of-Network*	Non-Delta Out-of-Network*
Calendar Year Deductible and Maximum			
Deductible (Individual / Family)	$50 per person $150 per family	$50 per person $150 per family	$50 per person $150 per family
Maximum per covered person	$2,500 per member	$2,500 per member	$1,500 per member
Services			
Diagnostic & Preventive Oral Exams, Prophylaxis (cleanings), X-rays	Covers 100% of DPO negotiated fee (deductible waived) Does not apply towards maximum annual benefit	Covers 100% of DPO negotiated fee (deductible waived) Does not apply towards maximum annual benefit	Covers 100% of program allowance
Basic Sealants, Fillings, Extractions, Anesthesia, Endodontics, Periodontics	Covers 100% of DPO negotiated fee	Covers 100% of Premier approved fee	Covers 100% of program allowance
Major Bridges, Crowns, Dentures	Covers 100% of DPO negotiated fee (dentures subject to maximum allowance)	Covers 100% of Premier approved fee (dentures subject to maximum allowance)	Covers 100% of program allowance (dentures subject to maximum allowance)
Prosthodontic Care			
Implants	Covers 100% of DPO negotiated fee	Covers 100% of Premier approved fee	Covers 100% of program allowance
Orthodontia Adult and Children	Covers 50% of DPO negotiated fee up to $2,000 lifetime maximum per person	Covers 50% of Premier approved fee up to $2,000 lifetime maximum per person	Covers 50% of program allowance up to $2,000 lifetime maximum per person

*Out-of-Network providers include both Premier dentists and Non-Delta affiliated dentists. Balance-billing will result with Non-Delta affiliated dentists.
For more details about the benefits provided by the dental plans, refer to their evidence of coverage (EOC) booklet.

Delta Care DHMO

The DeltaCare HMO Plan, administered by Delta Dental of California, is an "HMO" style dental plan with dentists throughout Santa Barbara, Ventura, and San Luis Obispo counties.

When you enroll in the DeltaCare HMO Plan, you must select a provider for yourself and each of your covered dependents from the plan's DeltaCare HMO Network Directory. If you do not obtain dental services through your primary care dental office, or if DeltaCare HMO has not authorized services elsewhere, you will not be covered. Under this plan, you have no claim forms to submit.

The chart provides a brief illustration of your Delta Care plan copayments.

To locate a network provider, go to **www.deltadentalins.com** and select ***Find a Provider***. Be sure to select your correct network. Network Name: **DeltaCare USA**

Delta Dental questions?
DHMO members – (800) 422- 4234

Copayment amounts represent member's responsibility.	Delta Care In-Network Only
Calendar Year Deductible and Maximum	
Deductible (Individual / Family)	None
Maximum per covered person	N/A
Services	
Diagnostic & Preventive Oral Exams, Prophylaxis (cleanings), X-rays, Sealants	100% covered
Basic Fillings, Extractions, Anesthesia, Endodontics, Periodontics	Scheduled copayments from $5 to $310
Major Bridges, Crowns, Dentures	Scheduled copayments from $0 to $295
Prosthodontic Care	
Implants	Not covered
Orthodontia Adult and Children	Scheduled copayments of $1,900 for adults; and $1,700 for children (Additional copayments apply for pre-orthodontic services and orthodontic retention)

For more details about the benefits provided by the dental plans, refer to their evidence of coverage (EOC) booklet.

Vision Benefits

The City of Santa Barbara provides vision coverage through VSP. You can see a VSP in-network provider or an out-of- network provider, however, your costs will be lower if you visit an in-network provider. If you visit an in-network provider, you will be responsible for a copayment at the time of your service. If you receive services from an out-of-network doctor, you will pay all costs at the time of service and submit a claim for reimbursement up to the allowance.

	Basic Plan		Buy-Up Plan	
	If You Use a VSP	If You Use Other	If You Use a VSP	If You Use Other
Eye Exam (1 every 12 months)	Covered in full after $15 copayment	Covers up to $50 after $15 copayment	Covered in full after $15 copayment	Covers up to $50 after $15 copayment
Eyeglass Lenses (1 pair every 12 months)	Single vision, bifocal, trifocal and lenticular lenses are covered in full	Covers up to: $50 for single vision; up to $75 for bifocal; up to $100 for trifocal; and up to $125 for lenticular	Single vision, bifocal, trifocal and lenticular lenses are covered in full	Covers up to: $50 for single vision; up to $75 for bifocal; up to $100 for trifocal; and up to $125 for lenticular
Eyeglass Frames	Covers up to $150 for frames (1 pair every 24 months)	Covers up to $70 for frames (1 pair every 24 months)	Covers up to $200 for frames (1 pair every 12 months)	Covers up to $70 for frames (1 pair every 12 months)
VSP Lightcare™ (Non-prescription Lenses and Frames)	Not included		Included	
Contact Lenses (fitting evaluation, and cost)				
Medically Necessary	Covered in full in lieu of frames and lenses	Covers up to $210 in lieu of frames and lenses	Covered in full in lieu of frames and lenses	Covers up to $210 in lieu of frames and lenses
Elective	Covers up to $150 every 12 months in lieu of frames and lenses	Covers up to $105 every 12 months in lieu of frames and lenses	Covers up to $200 every 12 months in lieu of frames and lenses	Covers up to $105 every 12 months in lieu of frames and lenses

Life and Disability

Basic Coverage

As a City employee, you automatically receive Group Term Life insurance and Accidental Death and Dismemberment (AD&D) coverage. The City pays the entire cost of this important protection, which is administered by The Standard. Benefit amounts are determined by employee groups. Refer to your Open Enrollment Worksheet for your City-paid coverage level.

Supplemental Coverage

During annual Open Enrollment you have the option to purchase additional or supplemental life insurance. This extra layer of supplemental life insurance protection is available
for yourself, your spouse and your children. The cost of supplemental coverage for yourself and your spouse is based on the amount of coverage elected and your age as a City employee. The amount of supplemental coverage for your spouse cannot exceed the amount of supplemental coverage for yourself. Evidence of insurability is required.

For Yourself – Choose up to $1,000,000 of coverage in $10,000 increments (not to exceed 8 times your annual earnings that combines the basic and supplemental life amounts).

For Your Spouse — Choose up to $500,000 or 100% of the amount of coverage for yourself, whichever is less, in $10,000 increments.

For Your Children – Each child is eligible from live birth up to age 26 for $2,000, $5,000 or $10,000 of coverage.

California State Disability Insurance (SDI)

(Applies to Supervisors, General, Confidential, and Treatment and Patrol employees)
California SDI coverage is provided through the State Disability Insurance program and it replaces part of your weekly base pay. Benefits begin on the 8th day of your illness or injury and continue for up to 52 weeks while you remain disabled. This coverage is paid by all covered employees through payroll deductions.

Short-Term Disability Insurance (STD)

(Applies to Managers and Police employees)
Eligible employees have the option to purchase voluntary STD benefits through The Standard. Rates, maximum benefit periods and maximum weekly benefits paid are determined by employee groups. Benefits begin on the 1st day of disability for an injury; and on the 4th day of disability for illness. This voluntary coverage is paid by enrolled employees through payroll deductions. Evidence of insurability may be required.

Long- Term Disability (LTD)

(Applies to General, Confidential, Treatment and Patrol, Supervisory, and Management employees)
The LTD Plan, administered by The Standard, offers financial assistance for unexpected injuries and illnesses that last for an extended period. The City pays the full cost of this protection. The plan pays a monthly benefit of 60% of pay up to a maximum monthly benefit amount. Benefits begin after a 90-day elimination period and continue for up to 3 years, 6 months or to the Social Security Normal Retirement Age (SSNRA). Benefits are reduced by any disability income you receive from other sources, such as other pension plans, Social Security, workers' compensation and state disability plans.

Employee Assistance Program (EAP)

Life does not always go smoothly. All of us experience times when a personal problem or crisis affects the way we function at work or home. Your Employee Assistance Program (EAP) is a problem-solving resource available to you and your household members. A professional counselor will assist you in assessing your situation, finding options, making choices or locating further help.

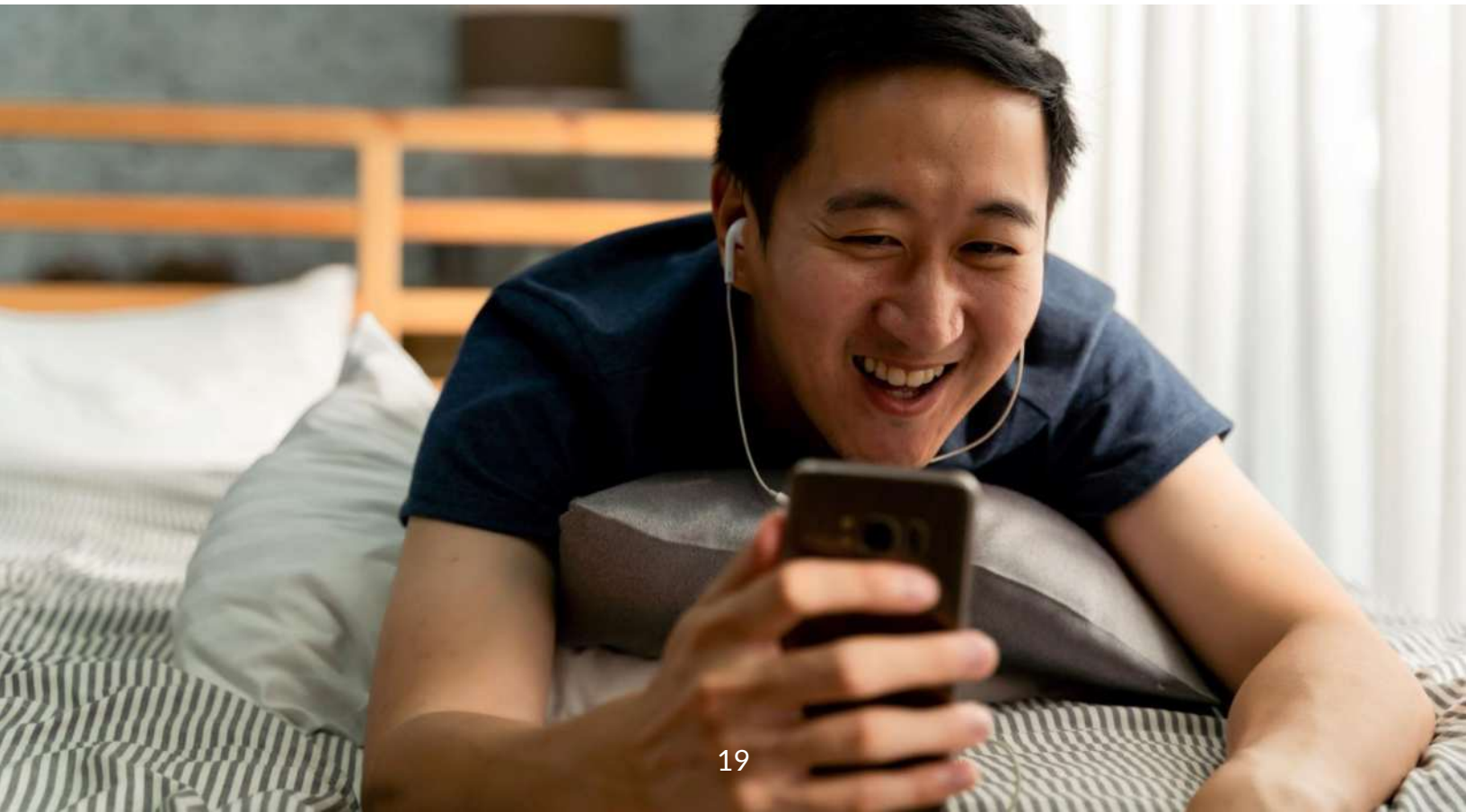
Emotional Wellbeing Solutions (EWS), The City's Employee Assistance Program administered by OptumHealth, offers up to three (3) free and confidential sessions per issue per individual per year with professional counselors. These services help you improve life at home and at work.

Through the EWS, a team of dedicated counselors is available to provide guidance on a wide range of issues from everyday concerns to serious problems–such as balancing home and work, elder care support, financial concerns, and resolving a substance abuse problem. Call the EAP at 1-866-828-6049 anytime, day or night, to connect with the people and resources you need to keep your life running smoothly.

Additional benefits are available through **www.liveandworkwell.com**, an interactive website that provides electronic access and delivery of your EAP benefits, as well as resources to help you enhance your work, health and life. Log on to **www.liveandworkwell.com** (access code 12605) to check your EAP benefits information; request services; look up health facts; read articles on work and career, family and relationships, and a host of life events issues; and utilize online tools for self- improvement programs.

1-866-828-6049

www.liveandworkwell.com
Access code: 12605



Your Right to Privacy

Respecting the privacy and security of your personal information is an important matter. Information that can identify you as a specific individual or information involving your health or medical history is considered protected health information. Protected health information about you may be used, but not limited to the following circumstances:

To process your benefit elections. The City and its designated benefits administrator(s) may use your personal information to process your benefit elections or to contact you if additional information is required.

To coordinate health coverage with other plans. The City and its designated benefits administrator(s) may disclose personal information to other companies that help process or service your health coverage or may correspond with you. For example, we may provide your personal information to a service provider to coordinate benefits coverage in the event you have healthcare coverage under more than one plan. Please be assured that these service providers are not allowed to use your personal information for their own purposes and are contractually obligated to maintain strict confidentiality.

To respond to legal obligations. We may disclose or report personal information when the disclosure is required or permitted under law, for example, to cooperate with regulators or law enforcement authorities.

COBRA Continuation

Under a law called the Consolidated Omnibus Budget Reconciliation Act (COBRA), you have the right to continue your group health plan participation beyond when your City coverage ends. If you or any of your dependents lose plan coverage as a result of eligibility, you or your dependents may be able to continue your group health plan choices through COBRA. A group health plan includes any medical plan, dental plan, vision plan, Employee Assistance Program and Flexible Spending Account. You must pay the full cost of the coverage, plus 2%. The duration of continued coverage through COBRA depends on your situation. This summary does not completely describe continuation coverage or any other rights under the plan. More detailed information regarding such rights can be requested from the Benefits Office at (805) 564-5400.

To Qualify for COBRA

COBRA allows you the optional election to continue your insurance plan when coverage would otherwise end because you have a life event, known as a "qualifying event", such as termination of employment or your loss of coverage from your spouse's employment. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees and dependent children of the employees may be qualified beneficiaries. Under the plan, qualified beneficiaries who elect COBRA continuation coverage are required to pay for COBRA continuation coverage.

You do not have to show that you are insurable in order to choose continuation coverage. However, an employee, spouse or dependent child must have been actually covered by the group health plan the day before the qualifying event in order to be eligible to elect COBRA coverage. Specific qualifying events by qualified beneficiaries include:

Employees. Employees have the right to elect continuation coverage if City-sponsored group health coverage is lost due to a reduction in hours of employment or the termination of employment (for reasons other than gross misconduct).

Spouses. Spouses of employees covered by the City sponsored group health plan have the right to choose continuation coverage if coverage under the City group health plan is lost for any of the following reasons:

- The death of the City employee
- Termination of the City employee's employment (for reasons other than gross misconduct)
- Reduction in the City employee's hours of employment
- Divorce or legal separation
- City employee becomes entitled to Medicare

Dependent Children. Dependent children covered by the City sponsored group health plan have the right to choose continuation coverage if coverage under the City group health plan is lost for any of the following reasons:

- The death of the parent-employee
- The parent-employee's employment ends (for reasons other than gross misconduct)
- Reduction in the parent-employee's hours of employment
- Parent's divorce or legal separation
- The parent-employee becomes entitled to Medicare benefits
- (Part A, Part B, or both)
- The dependent ceases to be a "dependent child" under the
- City's group health plan

Your Notice Obligations

Under the law, you or a family member have 60 days from (1) the date of the event or (2) the date on which coverage would be lost, whichever is later, to inform the City of the COBRA qualification. Written notification of the qualifying event must be submitted to the Benefits Office within 60 days. If you, your spouse or dependent child fails to provide this notice during the 60-day notice period, any spouse or dependent child who loses coverage will NOT be offered the option to elect continuation coverage. Keep copies of all notices that you send to the Benefits Office.

To Elect COBRA Coverage

When the Benefits Office is notified that there is a qualifying COBRA event, you will in turn be notified that you have the right to choose COBRA continuation coverage and will be sent an enrollment form. If you do not elect continuation coverage within the election period, then your rights to continue group health coverage will end.

If you choose continuation coverage and pay the applicable premium, the City is required to provide coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly-situated active employees or family members. If the City changes or ends group health coverage for similarly-situated active employees, your coverage will also change or end.

Ordinarily, the continuation coverage that is offered will be the same coverage that you, your spouse, or dependent children had on the day before the qualifying event. Therefore, an employee, spouse or dependent child who is not covered under the plan on the day before the qualifying event generally is not entitled to COBRA coverage except, for example, when there is no coverage because it was eliminated in anticipation of a qualifying event such as divorce. If the coverage is modified for similarly-situated employees or their spouses or dependent children, then COBRA coverage will be modified in the same way.

If you were covered under three separate plans (i.e., a medical plan, a dental plan and a vision plan), you could elect COBRA coverage under the medical plan, dental plan and vision plan or decline coverage under one or more of the same plans. If you were enrolled in a health care reimbursement account under which you are reimbursed for medical expenses, you, your spouse or dependent children may elect to continue the reimbursement account coverage under COBRA, but only if there is a positive account balance (i.e., year-to-date contributions exceed year-to-date claims) on the day before the qualifying event (taking into account all claims submitted by that date). COBRA coverage under the health reimbursement account will continue only for the remainder of the plan year in which the qualifying event occurred. If there is a negative account balance (i.e., year-to-date contributions are less than year-to-date claims), then no qualified beneficiary may elect COBRA coverage under the health reimbursement account.

Duration of COBRA Coverage

The following chart shows the maximum period for which COBRA must be offered to qualified beneficiaries for the specific qualifying events.

QUALIFYING EVENT	QUALIFIED BENEFICIARIES	MAXIMUM PERIOD OF COBRA
Employee ends employment (for reasons other than gross misconduct) or reduces hours of employment	Employee Spouse Dependent child	**18 months***
Employee enrollment in Medicare	Spouse Dependent child	**36 months**
Divorce or legal separation	Spouse & Dependent child	**36 months**
Death of employee	Spouse Dependent child	**36 months**
Loss of "dependent child" status under the plan	**Dependent child**	**36 months**

***In certain circumstances, qualified beneficiaries entitled to 18 months of COBRA may become entitled to extended COBRA periods.**

- Employees, Spouses, or Dependents with Disabilities. The 18-month COBRA period can be extended to 29 months if the Social Security Administration determines that the employee, spouse, or dependent child was disabled on the date of the qualifying event according to Title II (Old Age Survivors and Disability Insurance) or XVI (Supplemental Security Income) of the Social Security Act. Disabilities that occur after the qualifying event do not meet the criteria for the extended COBRA coverage period.
- Multiple Events. The 18-month COBRA period can be extended for dependents only, if during the 18-month period, a second event takes place, such as a parent(s) death, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a dependent. If this happens, the 18-month COBRA period may be extended to 36 months from the date of the original qualifying event. It is the responsibility of the employee, spouse, or dependent to notify the Benefits Office within 60 days of the event and within the original 18-month COBRA period. COBRA coverage will not extend beyond 36 months from the original qualifying event, no matter how many events occur.

COBRA Premiums

You must pay the entire applicable monthly premium for your continuation coverage, which generally cannot exceed 102% of the plan costs for an 18-month period. An exception exists for coverage of employees with disabilities during the extension from the 19th month to the 29th month. During that time, 150% of the plan cost may be charged. The group health plan may increase the cost that must be paid for COBRA coverage if the applicable premium increases.

The period for paying the initial COBRA premium following the election of coverage is 45 days. The initial COBRA premium payment may be charged for multiple months of coverage as the payment will include retroactive coverage for the period beginning after the date on which coverage would have been lost as a result of the qualifying event. There is a 30-day grace period following the date regularly scheduled monthly premiums are due. Only in the case of mental incapacity is any further extension permitted.

COBRA Cancellation

The law provides that continuation coverage may be cut short for any of the following reasons:

- The City no longer provides group health coverage to any of its employees
- The premium for continuation coverage is not paid in a timely manner
- The employee, spouse, or dependent child becomes covered, after the date he or she elects COBRA continuation coverage, under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have
- The employee or spouse becomes entitled to Medicare
- The employee, spouse, or dependent child extended continuation coverage to 29 months due to a Social Security Disability and a final determination has been made that he or she is no longer disabled
- The employee, spouse or dependent child notifies the Benefits Office that they wish to cancel continuation coverage

Conversion Privileges

At the end of the continuation coverage period, the employee, spouse, or dependent child will be allowed the option to enroll in an individual conversion health plan provided under the City of Santa Barbara group sponsored health plans. The benefits provided under such an individual conversion policy may not be identical to those provided under the plan. You may exercise this right in lieu of electing COBRA continuation coverage, or you may exercise this right after you have received the maximum continuation coverage available to you. You should note that if you enroll in an individual conversion policy, you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

Questions?

Questions concerning your COBRA continuation coverage rights should be addressed to the contacts below:

City of Santa Barbara – COBRA Administrator:
Non-Medical COBRA Benefits Service Center:

Benefit Coordinators Corporation
2 Robinson Plaza
Pittsburgh, PA 15205
800-685-6100

City of Santa Barbara – Benefits Office
735 Anacapa Street
Santa Barbara, CA 93101
Tel: 805-564-5400

Important Legal Notices Affecting Your Health Plan Coverage

Included Notices

- Newborns' and Mothers' Health Protection
- Women's Health and Cancer Rights Notice
- Notice of Special Enrollment Rights
- Patient Protection Disclosure
- Qualified Status Changes
- Medicare Part D Creditable Coverage Notice
- Notice of Privacy Policy and Procedures health insurance
- Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
- Health Insurance Marketplace Coverage Options

IMPORTANT NOTICE

This section of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully on page 26.

Newborns' and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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 you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- Coverage is lost under Medicaid or a State CHIP program; or
- You or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

Important Legal Notices Affecting Your Health Plan Coverage

PATIENT PROTECTION MODEL DISCLOSURE

The medical HMO plans in CalPERS generally 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 HMO 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, contact the appropriate insurance provider. For children, you may designate a pediatrician as the primary care provider.

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

Contact Information

Questions regarding any of this information can be directed to:

Charlie Lam
(805) 564-5442
Clam@SantaBarbaraCA.gov

QUALIFIED STATUS CHANGES

A qualified status change or qualifying event is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples include but are not limited to:

Involuntary Loss of other Coverage: If you previously declined health coverage under the City of Santa Barbara plan due to being covered through another plan such as your spouse's employer-sponsored plan or other insurance coverage, you may enroll within 60 days of the event date (or loss of coverage date). Involuntary loss of coverage is defined as:

- Termination of employment of the individual through whom the employee or dependent was covered
- Termination of the other plan's coverage
- COBRA continuation overage has been exhausted
- Termination of employer's contribution toward employee or dependent coverage
- Death, divorce, or legal separation of a person through whom the employee or dependent was covered

Marriage or Domestic Partnership: You may add your spouse or domestic partner and, if any, dependents (such as stepchild(ren) within 60 days of the event date (marriage date or domestic partnership registration date).

Death, Divorce or Termination of Domestic Partnership: You must remove your spouse or domestic partner due to death, divorce or termination of the domestic partnership registration. The effective date of the coverage termination date is the first of the month following the event date, e.g., death, divorce or termination of domestic partnership date. Please note that although a member's divorce decree may stipulate that they must provide health benefits for the ex-spouse or domestic partner, the ex-spouse cannot remain enrolled in CalPERS health benefits as a dependent as they are no longer considered an eligible family member. The ex-spouse or domestic partner may obtain coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Birth/Placement: You may add a newborn child or newly adopted child within 60 days of the event date.

Change in Employment Status: If your employment status changed from part-time to full-time, you may add health coverage within 60 days of the event date. A change in bargaining unit is not a qualifying event to change health plans.

Address Change: You may change your medical plan within 60 days of the physical address change date.

If such a change occurs, you must make the changes to your benefits within 60 days of the event date unless specified otherwise. Documentation will be required to verify your change of status. Failure to request a change of benefits within the allotted days of the event may result in you having to wait until the next Open Enrollment period to make your change. Please contact the Benefits Office at (805) 564-5400 if you have any questions regarding these changes.

Important Legal Notices Affecting Your Health Plan Coverage

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important Notice from City of Santa Barbara 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 City of Santa Barbara 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:

1. **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.**

2. **City of Santa Barbara has determined that the prescription drug coverage offered by CalPERS for the plan year 2026 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, the following options may apply.

- You may stay in the CalPERS and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose CalPERS creditable coverage.
- You may stay in CalPERS and also enroll in a Medicare prescription drug plan. CalPERS will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in CalPERS and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the CalPERS, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next Open Enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information.
NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **City of Santa Barbara** changes. You also may request a copy of this notice at any time.

Important Legal Notices Affecting Your Health Plan Coverage

MEDICARE PART D CREDITABLE COVERAGE NOTICE CONTINUED

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:

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

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

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

Date: September 8, 2025
Sender: City of Santa Barbara
Contact: Human Resources Dept. – Benefits Office
Address: 735 Anacapa Street,
Santa Barbara, CA 93101
Phone: (805) 564-5400

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.
Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights
You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices
You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures
We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Important Legal Notices Affecting Your Health Plan Coverage

NOTICE OF PRIVACY PRACTICES CONTINUED

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

<u>Your Choices</u>

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us.

Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information

<u>Our Uses and Disclosures</u>

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Important Legal Notices Affecting Your Health Plan Coverage

NOTICE OF PRIVACY PRACTICES CONTINUED

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice
January 1, 2026
- Contact the Privacy Official at City of Santa Barbara
- For the CalPERS Privacy Officer contact
  - 400 Q Street, Sacramento, CA 95811 or,
  - You may also call them at 888-225-7377
- For the WEX FSA Privacy contact
  - wexhealthprivacy@wexhealthinc.com,
  - You may also call them at 833-299-5095

Important Legal Notices Affecting Your Health Plan Coverage

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

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**

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information
Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.

Important Legal Notices Affecting Your Health Plan Coverage

note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution – as well as your employee contribution to employment-based coverage – is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a

Marketplace plan. There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023 . As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage. Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period.

That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan. Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaidchip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender: Charlie Lam
Address: 735 Anacapa Street, Santa Barbara, CA 93101
Phone Number: (805) 564-5400
clam@santabarbaraca.gov

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

Important Legal Notices Affecting Your Health Plan Coverage

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Employer name		Employer Identification Number (EIN)
City of Santa Barbara		95-6000787
Employer address		Employer phone number
735 Anacapa Street		(805) 564-5400
City	State	Zip code
Santa Barbara	CA	93101
Who can we contact about employee health coverage at this job?		
Charlie Lam		
Phone number (if different from above)		Email address
(805) 564-5442		Clam@SantaBarbaraCA.gov

Here is some basic information about health coverage offered by this employer:

- **As your employer, we offer a health plan to**:

  ☒ **All employees**. Eligible employees are: Full time and part time regular employees working at least 20 hours or more biweekly.

  ☐ **Some employees. Eligible employees are:** All regular, full-time employees working at least 30 hours per week are eligible. Your coverage will become effective on the first day of the month following or coinciding with your date of hire.

- **With respect to dependents**:

  ☒ **We do offer coverage. Eligible dependents are:** Legal spouse, state registered domestic partner, and children to age 26.

  ☐ **We do not offer coverage**.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

- If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums

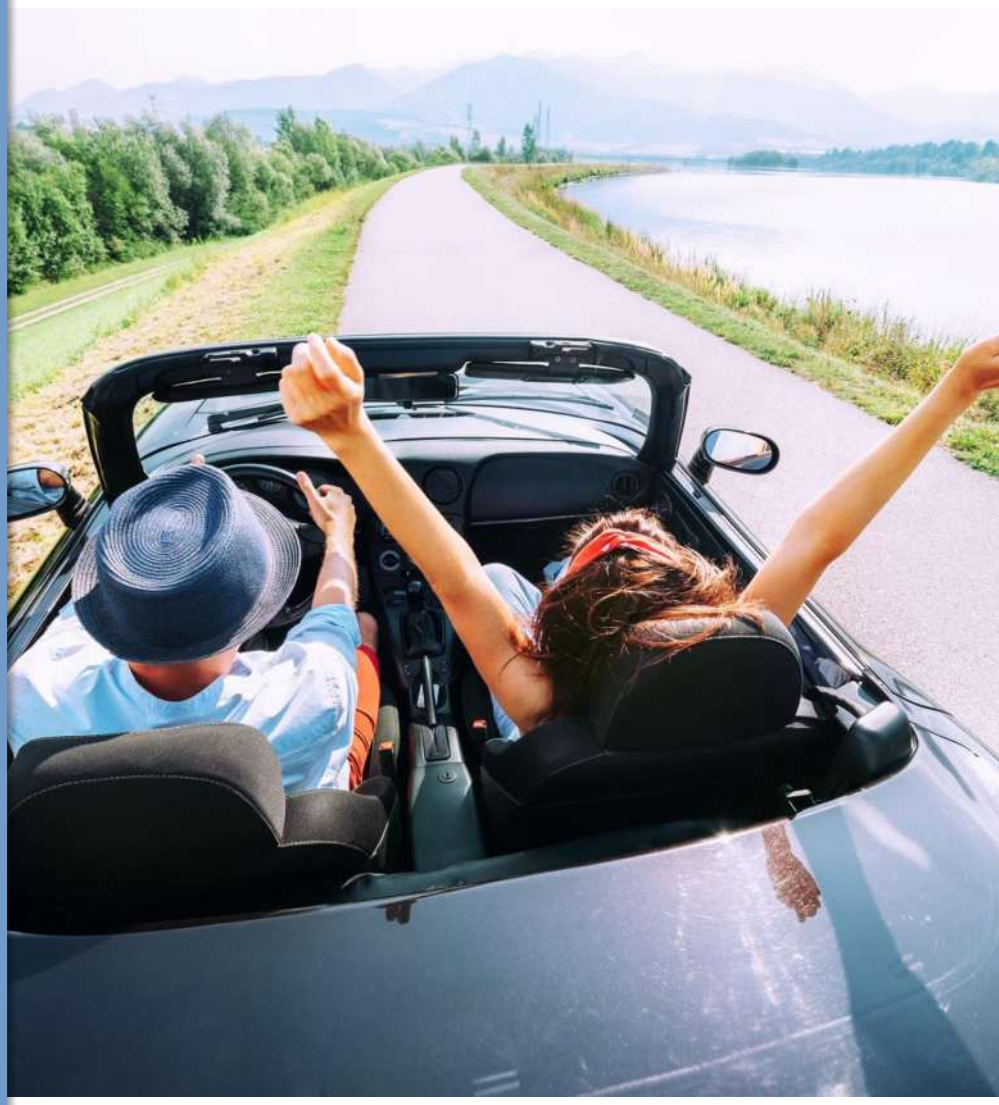
[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986).

Carrier Contacts

Use the information below to reach out to carriers directly regarding your benefits.

If you have questions about…		
Carrier	Call	Website
Medical Benefits CalPERS		
Anthem HMO	(855) 839-4524	anthem.com/ca/calpers
Blue Shield EPO	(800) 334-5847	blueshieldca.com/calpers
Blue Shield HMO	(800) 334-5847	blueshieldca.com/calpers
Health Net HMO	(888) 926-4921	calpers.healthnetcalifornia.com
Kaiser Permanente	(800) 305-1220	kp.org/calpers
Included Health (PPO Contact)		
PERS Gold	(855) 633-4436	includedhealth.com/calpers
PERS Platinum	(855) 633-4436	includedhealth.com/calpers
PORAC	(800) 655-6397	Ibtofporac.org
Sharp Health Plan	(855) 995-5004	calpers.sharphealthplan.com/
UnitedHealthCare HMO	(877) 359-3714	uhc.com
Western Health Advantage	(888) 942-7377	westernhealth.com/calpers
CVS Caremark	(833) 291-3649	www.caremark.com/calpers
FSAs		
WEX	(866) 451- 3399	https://benefitslogin.wexhealth.com
Dental Benefits		
Delta DPO Plan	(800) 765-6003	www.deltadentalins.com
DeltaCare USA HMO Plan	(800) 422-4234	www.deltadentalins.com
Vision		
VSP	(800) 877-7195	www.vsp.com
Employee Assistance Program (EAP)		
Optum Health	(866)-828-6049	www.liveandworkwell.com Access Code: 12605
Life, AD&D and Disability Insurance		
Standard - Life/AD&D	(800) 628-8600	https://www.standard.com
Standard - Short Term Disability	(800) 368-2859	https://www.standard.com
Standard - Long Term Disability	(800) 368-1135	https://www.standard.com
State Disability Insurance (SDI)	(800) 480-3287	https://edd.ca.gov/disability
COBRA		
Benefit Coordinator Corporation	(800) 685- 6100	

Notes



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