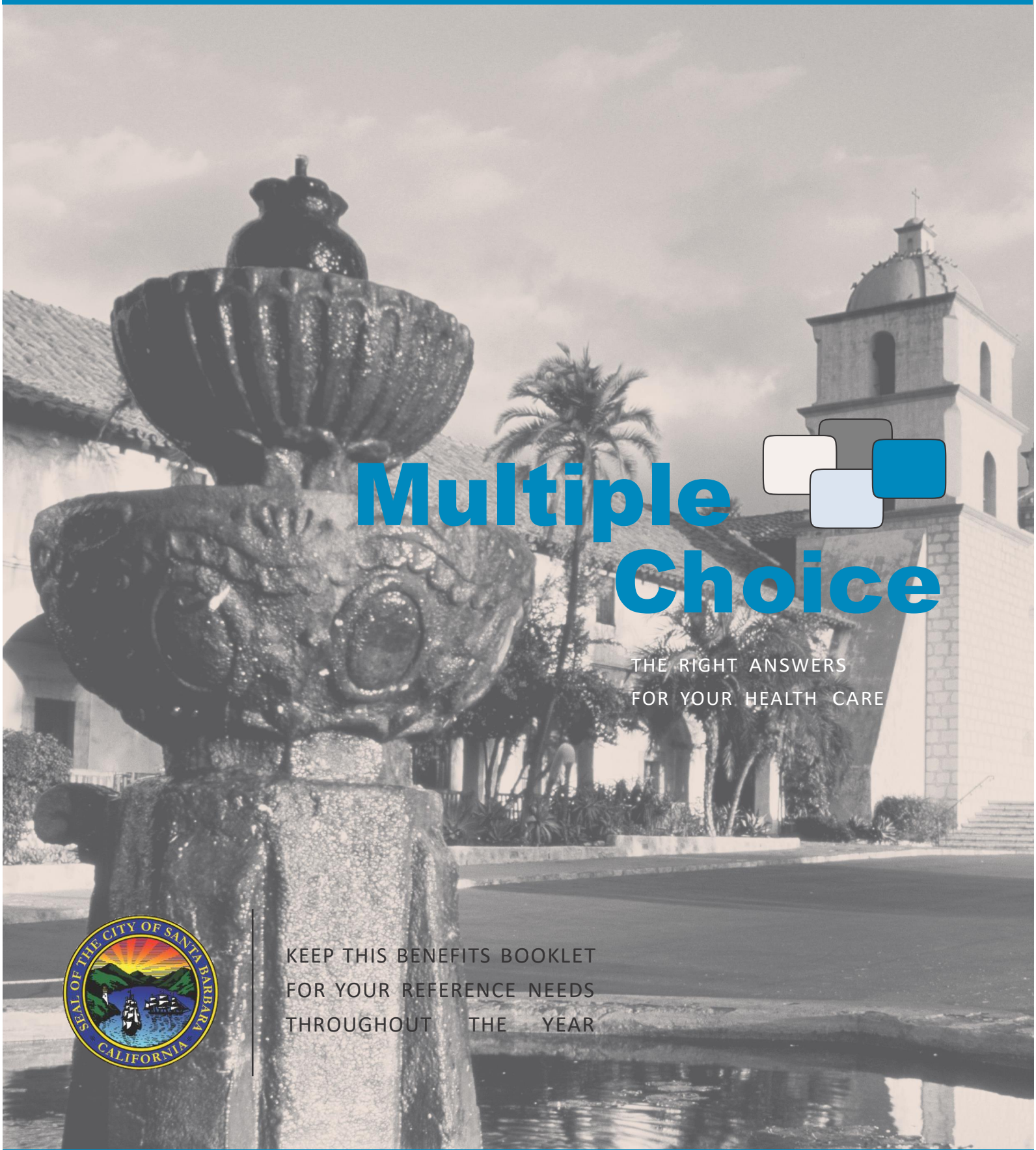
CITY OF SANTA BARBARA

2022 BENEFITS BOOKLET



Multiple Choice

THE RIGHT ANSWERS
FOR YOUR HEALTH CARE

KEEP THIS BENEFITS BOOKLET
FOR YOUR REFERENCE NEEDS
THROUGHOUT THE YEAR

What's Inside

This Benefits Booklet generally reviews dental, vision and other benefits for the City of Santa Barbara employees but it is not a contract. Full details about the benefits are provided in summary plan documents and insurance contracts that govern the programs. If there are differences between this Benefits Booklet and those documents and contracts, the governing documents and contracts will control. The summary plan documents may be inspected at the Benefits Office or a copy of the plan document(s) may be obtained from the Benefits Office or online from the Benefits SharePoint web site. This Benefits Booklet does not provide highlights of benefit changes, Open Enrollment reminders or Open Enrollment instructions. Refer to your Open Enrollment packet, or New Employee packet, for additional important information and disclosures. Please note that information contained in this Booklet is subject to change due to health care reform.

CITY OF SANTA BARBARA
2022 Benefits Summary

About Your Health Care Coverage

The City's benefit plan year begins each January 1st and ends December 31st. Benefit plans and rates are established each plan year.

Who Is Eligible

Active 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.

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

- Legal spouse, state-registered domestic partner, or local 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 31 days of the event)
- Children to age 26 for dental and vision coverage (including stepchildren, foster children, legally adopted children, children placed for the purpose of 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 that is moving away from home, you will need to contact the Benefits Office (see back cover) within 31 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 31 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 31 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 31 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).

When You Are Eligible

As 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.

Benefits are provided on the plan year basis January 1 through December 31. Annual Open Enrollment periods are provided each Fall for benefits effective the next plan year beginning January 1.

When first eligible
At the time of new hire, you will be provided enrollment materials for electing your benefit plans. You must enroll within 31 days of 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. Refer to the Rules for Benefit Changes During the Year listed on the following page.

At annual Open Enrollment
During the annual Open Enrollment period you can change your benefit plans, elect new benefit plans and add eligible dependents. The annual Open Enrollment period is typically in the Fall each year for plan year coverage effective January 1st.

When coverage ends

For most benefits, your coverage terminates the last day of the month in which you terminate or retire from City employment. However, CalPERS Medical coverage ends on the first day of the second month following your separation date. Premium for the additional month is the employee's responsibility, unless you specifically decline the additional month of medical coverage.

If you leave employment with the City or you or any of your covered dependents are no longer eligible to participate in the plan, continuation coverage under the law called Consolidated Omnibus Budget Reconciliation Act, or COBRA, is available. Refer to the COBRA Continuation information provided in this Benefits Booklet.

For continuing coverage under the City's group retiree plan, contact the Benefits Office.

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.

Contributions

Your contributions towards your coverage (if any are required), will be deducted from your paycheck on a before-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 July and December 2022, 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 to 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 the Qualified Status Change Chart beginning on page 20 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 or local 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 in work site or 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 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 31 days of the date the event (marriage, birth, change in employment status of your spouse or child, etc.) occurs. 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 31 days after your other coverage ends. 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, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If you or a family member lose 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 after the loss of coverage.

Medical Coverage

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 program such as Tricare, Medicare or Medi-Cal. Please note that individual medical coverage through an individual health plan or through 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 other group medical coverage is not provided to the Benefits Office, employees will be enrolled in the PERS Gold PPO medical plan at 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 the needs of you and your family. The CalPERS Health Benefit Summary Booklet provides an overview of the HMOs and PPOs. 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.

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 program 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 of your dependent coverage termination, or a change to your other group medical coverage during the year, you are required to provide notice to the Benefits Office within 31 days of the event. If your dependent coverage is terminated, within 31 days of the event you are required to enroll in a City-sponsored medical plan of your choice.

Note that if you waive medical coverage:

- You must submit a completed Employee Waiver Form along with proof of other coverage to the Benefits Office for your waiver to be processed.
- You will receive a cash back amount as determined by your memorandum of understanding, but only after the required paperwork has been submitted and approved.
- Your cash back amount will be reduced by the City cost of any dental and vision coverage you select
    - You must wait until the next annual Open Enrollment period to enroll for medical coverage or add dependent coverage unless you have a qualified status change as described above.

Medical Coverage

Overview of your Medical Plan Options – Multiple Ways to Access Health Care

It's great to have options, but you want to choose the one that's right for you. START…by looking at the following charts. They describe the basic features of the HMO and PPO plans. Refer to the individual plan Summary of Benefits and Coverage schedules available on the Benefits Enrollment website or on the Benefits SharePoint website, or from the Benefits Office for more detailed information.

Benefits	Anthem Blue Cross Select HMO Traditional HMO	Blue Shield Access+ HMO & Trio HMO	Kaiser Permanente	UnitedHealthcare Signature Value Alliance
Calendar Year Deductible				
• Individual	N/A	N/A	N/A	N/A
• Family	N/A	N/A	N/A	N/A
Maximum Calendar Year Copay or Coinsurance (*excluding pharmacy)*				
• Individual	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)
• Family	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)
Hospital (*including Mental Health and Substance Abuse)*				
• Deductible *(per admission)*	N/A	N/A	N/A	N/A
• Inpatient	No Charge	No Charge	No Charge	No Charge
• Outpatient Facility/Surgery Services	No Charge	No Charge	$15	No Charge
Emergency Services				
• Emergency Room Deductible	N/A	N/A	N/A	N/A
• Emergency *(copay waived if admitted as an inpatient or for observation as an outpatient)*	$50	$50	$50	$50
• Non-Emergency *(copay waived if admitted as an inpatient or for observation as an outpatient)*	$50	$50	$50	$50
Physician Services *(including Mental Health and Substance Abuse)*				
• Office Visits *(copay for each service provided)*	$15	$15	$15	$15
• Inpatient Visits	No Charge	No Charge	No Charge	No Charge
• Outpatient Visits	$15	$15	$15	$15
• Urgent Care Visits	$15	$15	$15	$15
• Preventive Services	No Charge	No Charge	No Charge	No Charge
• Surgery/Anesthesia	No Charge	No Charge	No Charge	No Charge
Diagnostic X-Ray/Lab				
	No Charge	No Charge	No Charge	No Charge
Prescription Drugs				
• Deductible	N/A	N/A	N/A	N/A
• Retail Pharmacy *(not to exceed 30-day supply)*	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $5 Brand Formulary: $20 Non-Formulary: $50	Generic: $5 Brand: $20	Generic: $5 Brand Formulary: $20 Non-Formulary: $50
• Retail Preferred Pharmacy Maintenance Medications	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	N/A	Generic: $10 Brand Formulary: $40 Non-Formulary: $100
• Mail Order Pharmacy Program *(not to exceed 90-day supply for maintenance drugs)*	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand Formulary: $40 Non-Formulary: $100	Generic: $10 Brand: $40 (31-100 day supply)	Generic: $10 Brand Formulary: $40 Non-Formulary: $100
• Mail order maximum copayment per person per calendar year	$1,000	$1,000	N/A	$1,000
Durable Medical Equipment				
	No Charge	No Charge	No Charge	No Charge
Infertility Testing/Treatment				
	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges

Medical Coverage (continued)

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

Benefits	Anthem Blue Cross Select HMO Traditional HMO	Blue Shield Access+ HMO & Trio HMO	Kaiser Permanente	UnitedHealthcare Signature Value Alliance
Occupational /Physical/Speech Therapy				
• Inpatient *(hospital or skilled nursing facility)*	No Charge	No Charge	No Charge	No Charge
• Outpatient (office and home visits)	$15	$15	$15	$15
Diabetes Services				
• Glucose monitors	Coverage Varies	No Charge	No Charge	Coverage Varies
• Self-management training	$15	$15	$15	$15
Acupuncture				
	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)
Chiropractic				
	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)

Medical Coverage (continued)

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

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Calendar Year Deductible						
• Individual	$1,000		$500		$300	$600
• Family	$2,000		$1,000		$900	$1,800
Maximum Calendar Year Copay or Coinsurance (*excluding pharmacy)*						
• Individual	$3,000 (coinsurance)	Unlimited	$2,000 (coinsurance)	Unlimited	$2,000	Unlimited
• Family	$6,000 (coinsurance)	Unlimited	$4,000 (coinsurance)	Unlimited	$4,000	Unlimited
Hospital *(including Mental Health and Substance Abuse)*						
• Deductible *(per admission)*	N/A		$250		N/A	
• Inpatient	20%	40%	10%	40%	20%	20%
• Outpatient Facility/ Surgery Services	20%	40%	10%	40%	20%	20%
Emergency Services						
• Emergency Room Deductible	$50 (applies to hospital emergency room charges only)		$50 (applies to hospital emergency room charges only)		N/A	
• Emergency	20% (applies to other services such as physician, x-ray, lab, etc.)		10% (applies to other services such as physician, x-ray, lab, etc.)		20%	
• Non-Emergency	20% *(payment for physician charges only; emergency room facility charge is not covered)*	40%	10% *(payment for physician charges only; emergency room facility charge is not covered)*	40%	50% *(payment for physician charges only; emergency room facility charge is not covered)*	
• Office Visits *(copay for each service provided)*	$35	40%	$20	40%	$10/$35	20%
• Inpatient Visits	20%	40%	10%	40%	20%	20%
• Outpatient Visits	$35	40%	$20	40%	20%	20%
• Urgent Care Visits	$35	40%	$35	40%	$35	20%
• Preventive Services	No Charge	40%	No Charge	40%	No Charge	
• Surgery/Anesthesia	20%	40%	10%	40%	20%	20%
Diagnostic X-Ray/Lab						
	20%	40%	10%	40%	20%	20%
Prescription Drugs						
• Deductible	N/A		N/A		N/A	
• Retail Pharmacy *(not to exceed 30-day supply)*	Generic: $5 Formulary: $20 Non-Formulary: $50		Generic: $5 Formulary: $20 Non-Formulary: $50		Generic: $10 Brand Formulary: $25 Non-Formulary: $45 Compound: $45	
• Retail Preferred Pharmacy Maintenance Medications	Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100		N/A	
• Mail Order Pharmacy Program *(not to exceed 90-day supply for maintenance drugs)*	Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $10 Preferred: $40 Non-Preferred: $100		Generic: $20 Brand Formulary $40 Non-Formulary: $75	N/A
• Mail order maximum copayment per person per calendar year	$1,000		$1,000		N/A	

Medical Coverage (continued)

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

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

Dental Coverage

The City offers a choice of two dental plans. You may choose the Delta DPO Plan or the DeltaCare HMO Plan.

Delta DPO Plan

The Delta DPO 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 stay in-network and choose a Delta DPO 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. You may also have to pay your entire bill in advance and then file a claim for reimbursement.

DeltaCare HMO Plan

The DeltaCare HMO Plan, administered by Delta Dental of California, is an "HMO" style dental plan with over 50 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 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 Dental plan options.

DENTAL PLAN HIGHLIGHTS			
Benefits/Services	Delta DPO Plan		DeltaCare HMO Plan DeltaCare HMO Providers
	Delta DPO Network	Out-of-Network	
Annual Deductible (amount you pay before plan makes payments)	$50 per person $150 per family		None
Maximum Annual Benefit	$1,500 per person	$1,500 per person	N/A
Diagnostic Preventive Care Exams, X-rays, cleanings	Plan pays 100% of DPO approved fee (deductible waived) Does not apply towards maximum annual benefit	Plan pays 100% of Delta approved fee	Plan pays 100%
Basic Care Fillings, extractions	Plan pays 100% of DPO approved fee	Plan pays 100% of Delta approved fee	Scheduled co-pays from $5 to $310
Crowns, Jackets & Cast Restorations	Plan pays 100% of DPO approved fee	Plan pays 100% of Delta approved fee	Scheduled co-pays from $10 to $295
Prosthodontic Care			
Bridges, dentures	Plan pays 100% of DPO approved fee (dentures subject to maximum allowance)	Plan pays 100% of Delta approved fee (dentures subject to maximum allowance)	Scheduled co-pays from $0 to $295
Implants	Plan pays 100% of DPO approved fee	Plan pays 100% of Delta approved fee	Not covered
Orthodontia (adult and children)	Plan pays 50% of DPO approved fee up to $2,000 lifetime maximum per person	Plan pays 50% of Delta approved fee up to $2,000 lifetime maximum per person	Scheduled co-pays of $1,900 for adults age 18 and over; and $1,700 for children (Additional co-pays apply for pre-orthodontic services and orthodontic retention)

*Out-of-Network providers include both Non-Delta DPO and Non-Delta dentists.

Vision Coverage

Vision coverage is available through Vision Service Plan (VSP). You may use any vision care provider, but if you use a VSP provider, you get the most value from your VSP benefit. With VSP providers there are no cards, no claim forms and no hassles. With other providers, you must pay the bill in full and file a claim for reimbursement within 180 days of the date of service.

Vision Plan		
	If You Use a VSP Provider	If You Use Other Provider
Eye Exam (1 every 12 months)	Covered in full after $15 copay	Plan pays up to $50 after $15 copay
Eyeglass Lenses (1 pair every 12 months)	Single vision, bifocal, trifocal and lenticular lenses are covered in full	Plan pays up to: $50 for single vision; up to $70 for bifocal; up to $100 for trifocal; and up to $125 for lenticular
Eyeglass Frames (1 pair every 24 months)	Plan pays up to $140 for frames	Plan pays up to $70 for frames
Contact Lenses (fitting, evaluation and cost)		
Medically Necessary	Covered in full in lieu of frames and lenses	Plan pays up to $210 in lieu of frames and lenses
Elective	Plan pays up to $140 every 12 months in lieu of frames and lenses	Plan pays up to $105 every 12 months in lieu of frames and lenses

Flexible Spending Accounts

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 $2,750 per year to the Health Care Spending Account, and up to $5,000 per year to the Dependent Care Spending Account (or up to $2,500 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 April, July, September and December 2022 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 the Qualified Status Changes – Election Change Chart at the back of the Benefits Booklet).
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. Your 2021 FSA will not rollover to 2022. To contribute to an FSA for 2022, you must elect the FSA and your annual contribution pledge through the online Benefits Enrollment Website.
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 2021 plan participant, you have a total period from January 1, 2022 through March 15, 2023 (14 ½ months) to incur eligible expenses for reimbursement of your 2021 contributions. To avoid 2021 forfeitures, claims must be filed by the deadline of March 31, 2023.
6. Your health care FSA benefit credit card may be used during the grace period, (January 1 – March 15, 2022); funds will come out of your 2021 account first.
7. 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 deductible, copayments, 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 that 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 above. This example assumes: 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 1/2 months grace period after the end of the plan year (December 31) to accumulate expenses to file for reimbursement of remaining account funds. For 2022 contributions, the grace period is through March 15, 2023. Claims for reimbursement of 2023 contributions must be filed by the deadline of March 31, 2023. Any remaining plan year 2022 contributions in your FSA account after March 31, 2023 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

Employee Assistance Program (EAP)

The City's Employee Assistance Program, administered by OptumHealth, offers up to three (3) free and confidential sessions with a professional counselor. These services help you improve life at home and at work.

Through the EAP, 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 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.

Life & AD&D Insurance

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 Hartford Life Insurance Company. 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 on yourself. Evidence of good health is required.

For Yourself — Choose up to $500,000 of coverage in $10,000 increments.

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.

Disability Insurance

If you become disabled and cannot work, no benefit becomes more important to your financial security than disability income protection.

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 Hartford. 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 good health may be required.

Long-Term Disability Insurance (LTD)

(Applies to General, Confidential, Treatment and Patrol, Supervisory, and Management employees)
The LTD Plan, administered by Hartford, 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 48 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.

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 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 would end. 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. But 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 beneficiary 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.

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.

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.

- 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 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

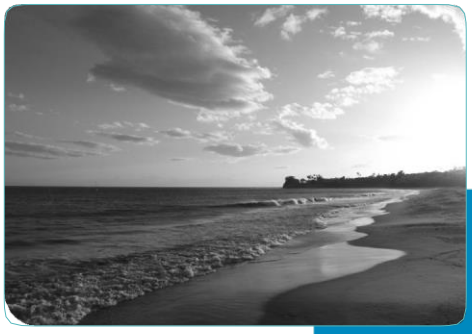
At the end of the continuation coverage period, the employee, spouse or dependent child will be allowed the option to enroll in an individual conversion health plan provided under the City of Santa Barbara group sponsored health plan if such conversion plan is available. The benefits provided under such 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
Pittsburg, PA 15205
800-685-6100

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



Newborn's and Mother's 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 within30 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 30 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 Notice About Your Prescription Drug Coverage and Medicare

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will 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 do decide to join a Medicare drug plan, your current CalPERS coverage will not be affected. If you do decide to join a Medicare drug plan and drop your CalPERS coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the City of 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 Benefits Office for further information. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Santa Barbara changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage…

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

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

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

Date:	January 1, 2022
Name of Entity/Sender:	City of Santa Barbara
Contact--Position/Office:	Human Resources Department – Benefits Office
Address:	735 Anacapa Street, Santa Barbara, CA 93101
Phone Number:	(805) 564-5400

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).

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November 2021 for coverage starting as early as January 1, 2022.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

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.

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.

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.

3. Employer name City of Santa Barbara	4. Employer Identification Number (EIN) 95-6000787	
5. Employer address 735 Anacapa Street	6. Employer phone number (805) 564-5400	
7. City Santa Barbara	8. State CA	9. ZIP code 93101
10. Who can we contact about employee health coverage at this job? Charlie Lam		
11. Phone number (if different from above) (805) 564-5442	12. Email address clam@santabarbaraca.gov	

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

- As your employer, we offer a health plan to:
  - [x] All employees. Eligible employees are:

    Full time and part time regular employees working at least 40 hours or more biweekly

  - [ ] Some employees. Eligible employees are:

- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    Legal spouse, registered domestic partner, and children to age 26

  - [ ] We do not offer coverage.

[x] 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

* 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)

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 designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact CalPERS at (888) 225-7377.

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

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 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.

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.

Your Choices

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

Our Uses and Disclosures

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.

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, 2022
- Contact the Privacy Official at City of Santa Barbara

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

TEXAS – Medicaid	WYOMING – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

Qualified Status Changes – Election Change Chart

The following chart shows the election changes that may be made under the Plan with respect to each Benefit Plan Option based on qualified status changes. In addition, election changes that are permitted under this Plan are subject to any limitations imposed by the Benefit Plan Options. If an election change is permitted by this Plan but not by the Benefit Plan Option, no election change under this Plan is permitted.

The effective date of eligible plan changes is the first of the month following the date of your qualified status change.

Refer to the Qualified Status Changes - Election Change Chart provided in the back of this Benefits Booklet for complete descriptions of qualified status changes under the plan and the related election changes that may be made.

CalPERS Health Plans follow different rules for qualified status changes. Refer to the CalPERS Health Program Guide for additional detail on CalPERS Rules.

QUALIFIED STATUS CHANGE	BENEFIT PLAN OPTIONS			
	Dental and Vision	Health Care FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
I. Change in Status				
A. Change in Employee's Legal Marital Status	Employee may enroll or increase election for newly- eligible spouse and dependent children (Note: Under IRS "tag-along" interpretation, new and pre-existing dependents may be enrolled); coverage option (e.g., HMO to PPO) change may be made; employee may revoke or decrease employee's or dependent's coverage only when such coverage becomes effective or is increased under the spouse's plan. Also, see HIPAA special enrollment rights on page 4.	Employee may enroll or increase election for newly eligible spouse or dependents, or likely decrease election if employee or dependents become an eligible dependent under new spouse's health plan (Note: HIPAA special enrollment rights likely do not apply).	Employee may enroll or increase to accommodate newly-eligible dependents or decrease or cease coverage if new spouse is not employed or makes a Dependent Care FSA coverage election under spouse's plan.	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not impacted.
1. Lose spouse (divorce, legal separation, annulment, death of spouse) (See loss of dependent eligibility on the next page for discussion of dependent eligibility loss following divorce, separation, etc.)	Same as previous column (Note: HIPAA special enrollment rights likely do not apply).	Employee may decrease election for former spouse who loses eligibility (Note: HIPAA special enrollment rights likely do not apply). Employee may enroll or increase election where coverage lost under spouse's health plan.	Employee may enroll or increase to accommodate newly eligible dependents (e.g., due to death of spouse) or decrease or cease coverage if eligibility is lost (e.g., because dependent now resides with ex-spouse).	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not impacted.
B. Change in the Number of Employee's Dependents				
1. Gain Dependent (birth, adoption)	Same as previous column. (Note: HIPAA special enrollment rights likely do not apply).	Same as previous column (Note: HIPAA special enrollment rights likely do not apply).	Employee may enroll or increase to accommodate newly eligible dependents (and any other dependents who were not previously covered under IRS "tag-along" rule).	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not impacted.

QUALIFIED STATUS CHANGE	BENEFIT PLAN OPTIONS			
	Dental and Vision	Health Care FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
2. Lose Dependent (death)	Same as previous column.	Employee may decrease or cease election for dependent who loses eligibility.	Employee may decrease or cease election for dependent who loses eligibility.	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not impacted.
C. Change in Employment status of Employee, Spouse, or Dependent that Affects Eligibility				
1. Commencement of Employment by Employee, Spouse, or Dependent (or Other Change in Employment Status) That Triggers Eligibility				
a. Commencement of Employment by Employee or Other Change in Employment Status (e.g., PT to FT, hourly to salaried, etc.) Triggering Eligibility Under Component Plan	Provided eligibility was gained for this coverage, employee may add coverage for employee, spouse, or dependents and coverage option (e.g., HMO to PPO) change may be made.			Employee may enroll, increase, decrease, or cease coverage even when eligibility is not impacted.
b. Commencement of Employment by Spouse or Dependent or Other Change in Employment Event Triggering eligibility Under Their Employer's Plan	Employee may revoke or decrease election as to employee's, spouse's, or dependent's coverage if employee, spouse or dependent is added to spouse's or dependent's coverage; coverage option (e.g., HMO to PPO) change may be made.	Employee may decrease or cease FSA election in accordance to the event.	Employee may make or increase election to reflect new eligibility (e.g., if spouse previously did not work). Employee may revoke election as to dependent's coverage if dependent is added to spouse's plan.	Employee may enroll, increase, decrease, or cease coverage even when eligibility is not impacted.
2. Termination of Employment by Employee, Spouse, or Dependent (or Other Change in Employment-Status) That Cause Loss Of Eligibility				
a. Termination of Employee's Employment or Other Change In Employment Status (e.g., unpaid leave, FT to PT, strike, salaried to hourly, etc) Resulting in a Loss of eligibility	Employee may revoke or decrease election for employee, spouse or dependents who lose eligibility under the plan. In addition, other previously eligible dependents may also be enrolled under "tag-along" rule. Coverage option (HMO to PPO) change may be made.		Employee may revoke or decrease election to reflect loss of eligibility.	Employee may enroll, increase, decrease or cease coverage even when eligibility is not affected.

QUALIFIED STATUS CHANGE	BENEFIT PLAN OPTIONS			
	Dental and Vision	Health Care FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
i. Termination and Rehire Within 30 days	Prior elections at termination are reinstated unless another event has occurred that allows a change (as an alternative, employer may prohibit participation until next plan year).			
ii. Termination and Rehire after 30 days	Employee may make new elections.			
b. Termination of Spouse's, or Dependent's Employment (or other change in employment status resulting in a loss of Eligibility under their employer's plan)	Same as previous column (Note: HIPAA special enrollment rights likely do not apply).	Employee may enroll or increase FSA election if spouse or dependent loses eligibility for health coverage (Note: HIPAA special enrollment rights likely do not apply).	Employee may enroll or increase if spouse or dependent loses eligibility for Dependent Care FSA. Employee may decrease or cease Dependent Care FSA election if spouse's loss of employment renders dependents ineligible.	Employee may enroll, increase, decrease or cease even when eligibility is not affected.
D. Event Causing Employee's Dependent to Satisfy or Cease to Satisfy Eligibility Requirements (Also see discussion of gain/loss of eligibility under their employer's plan)				
1. Event by Which Dependent Satisfies Eligibility Requirements Under Employer's Plan (attaining a specified age, becoming single, becoming a student, etc.)	Employee may enroll or increase election for affected dependent. In addition, employee may apparently add previously eligible (but not enrolled) dependents under "tag-along" rule; coverage option (e.g., HMO to PPO) change may be made.	Employee may increase election or enroll only if dependent gains eligibility under Healthcare FSA.	Employee may increase election or enroll to take into account expenses of affected dependent.	Employee may enroll, increase, decrease or cease even when eligibility is not affected.
2. Event by Which Dependent Ceases to Satisfy Eligibility Requirements Under Employer's Plan (attaining a specified age, getting married, ceasing to be a student, etc.)	Employee may decrease or revoke election only for affected dependent. Coverage option (e.g., HMO to PPO) change may be made.	Employee may decrease election to take into account ineligibility of expenses of affected dependent, but only if eligibility is lost.	Employee may decrease or drop election to take into account expenses of affected dependent.	Employee may enroll, increase, decrease or cease even when eligibility is not affected.'
E. Change in Place of Residence of Employee, Spouse, or Dependent				
1. Move Triggers Eligibility	Employee may enroll or increase election for newly eligible employee, spouse, or dependent. Also, other previously eligible dependents may be re-enrolled under "tag-along" rule; coverage option (e.g., HMO to PPO) change may be made.	No change permitted, even if underlying health coverage change occurs.	N/A. Dependent care eligibility is not generally affected by place of residence (but see change in coverage below).	Employee may increase or decrease even if spouse's or dependent's eligibility is not affected.

QUALIFIED STATUS CHANGE	BENEFIT PLAN OPTIONS			
	Dental and Vision	Health Care FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
2. Move Causes Loss of Eligibility (e.g., employee or dependent moves outside HMO Service area)	Employee may revoke election or make new election if the change in residence affects the employee's, spouse's or dependent's eligibility for coverage option.	No change permitted, even if underlying health coverage change occurs.	N/A. Dependent care eligibility is not generally affected by place of residence (but see change in coverage below).	Employee may enroll, increase, decrease or cease even when eligibility is not affected.
II. Cost Changes With Automatic Increase/ Decrease in Elective Contributions (including employer motivated changes and changes in employee contribution rates)	Plan may automatically increase or decrease (on a reasonable and consistent basis) affected employees' elective contributions under the plan, so long as the terms of the plan require employees to make such corresponding changes.	No change permitted.	Application is unclear. Presumably, plan may automatically increase or decrease (on a reasonable and consistent basis) affected employees' elective contributions under the plan, so long as the terms of the plan require employees to make such corresponding changes.	Same as Major Medical column.
III. Significant Cost Changes	Significant Cost Increase: Affected employee may increase election correspondingly OR revoke election and elect coverage under another benefit package option providing similar coverage. If no option providing similar coverage is available, employee may revoke election. Significant Cost Decrease: Employees may elect coverage (even if had not participated before) with decreased cost, and may drop election for similar coverage option. Though unclear, it appears that tag-along concepts may apply.	No change permitted.	Same as Major Medical column for significant cost increase, except no change can be made when the cost change is imposed by a dependent care provider who is a relative of the employee.	
IV. Significant Coverage Curtailment (With or Without Loss of Coverage)	Without Loss of Coverage: Affected participant may revoke election for curtailed coverage and make new prospective election for coverage under another benefit package option which provides similar coverage. With Loss of Coverage: Affected participant may revoke election for curtailed coverage and make new prospective election for coverage under another benefit package option which provides similar coverage OR drop coverage if no similar benefit package option is available.	No change permitted.	Election change may apparently be made whenever there is a change in provider or a change in hours of dependent care.	Same as Major Medical column.
V. Addition or Significant Improvement of Benefit Package Option	Eligible employees (whether currently participating or not) may revoke their existing election and elect the newly added (or newly improved) option. Though unclear, it appears that tag-along concepts may apply.	No change permitted.	Employee may decrease or revoke election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under other employer plan.	

QUALIFIED STATUS CHANGE	BENEFIT PLAN OPTIONS			
	Dental and Vision	Health Care FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
VI. Change in Coverage under Another Employer's Cafeteria Plan or Qualified Benefits Plan (In order for election changes to be permitted under this exception, the election change must be on account of and correspond with the change in coverage under the other employer's cafeteria plan or qualified benefits plan. In addition, either (1) the plan of the other employer must permit elections specified under the Regulations and an election must actually, be made under such plan; or (2) the employee's cafeteria plan must permit elections for a period of coverage different from that under the other employer plan ("Election Lock" rule).	Employee may decrease or revoke election for employee, spouse or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under another employer plan.	No change permitted.	Employee may decrease or revoke election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under another employer plan.	
A. Other Employer's Plan Increases Coverage	Employee may decrease or revoke election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under another employer's plan.	No change permitted.	Employee may decrease or revoke election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding increased coverage under another employer's plan.	
B. Other Employer's Plan Decreases or Ceases Coverage	Employee may enroll or increase election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding decreased coverage under another employer's plan.	No change permitted.	Employee may increase election for employee, spouse, or dependents if employee, spouse, or dependents have elected or received corresponding decreased coverage under other employer's plan.	
C. Open Enrollment Under Plan of Other Employer	Corresponding changes can be made under employer's plan.	No change permitted.	Corresponding changes can be made under employer's plan.	
VII. FMLA Leave (Employees can fund this coverage by (1) pre-paying their contribution obligations on a pre-tax basis (so long as the leave does not straddle two plan years); or (2) making contributions on a month-by-month basis (pre-tax if they are receiving salary continuation payments)				
A. Employee's Commencement of FMLA Leave	Employee can make same elections as employee on non-FMLA leave. In addition, an employer must allow an employee on unpaid FMLA leave either to revoke coverage or to continue coverage by paying employee share of the contribution during the leave. FMLA also allows an employer to require that employees on paid FMLA leave continue coverage if employees on non-FMLA paid leave are required to continue coverage.		Employee may revoke election and make another election as provided under FMLA.	

QUALIFIED STATUS CHANGE	BENEFIT PLAN OPTIONS			
	Dental and Vision	Health Care FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
B. Employee's Return from FMLA	Employee may make a new election if coverage terminated while on FMLA leave. In addition, an employer may require an employee to be reinstated in his or her election upon return from leave if employees who return from a non-FMLA paid leave are required to be reinstated in their elections.	Same as previous column. Note that, upon return, an employee whose coverage has lapsed has the right to resume coverage at prior coverage level (and make up unpaid premiums) or at a level reduced prorate for the missed contributions.	Employee may make a new election if coverage terminated while on FMLA leave. In addition, an employer may require an employee to be reinstated in his or her election upon return from leave if employees who return from a non-FMLA leave are required to be reinstated in their elections.	
VIII. HIPAA Special Enrollment Rights (See also HIPAA Special Enrollment Rights on Page 4)	No change permitted.			
A. Special Enrollment for Loss of Other Health Coverage	No change permitted.			
B. Special Enrollment for Acquisition of New Dependent by Birth, Marriage, Adoption, or Placement for Adoption (If newborn or newly adopted child is enrolled under HIPAA's special rules, child's coverage may be retroactive to date of birth, adoption, or placement for adoption; employee may change salary reduction election to pay for extra cost of child's coverage retroactive to date of birth, adoption, or placement for adoption. For marriage, coverage is effective prospectively.)	No change permitted.			
C. Special Enrollment for Loss of Coverage Under Medicaid or a State Children's Health Plan Because of Loss of Eligibility	No change permitted.			
D. Special Enrollment Because of Eligibility for Financial Assistance from Medicaid or a State Children's Health Plan Towards the Cost of Coverage under the Group Health Plan	No change permitted.			
IX. COBRA Events	No change permitted.			

QUALIFIED STATUS CHANGE	BENEFIT PLAN OPTIONS			
	Dental and Vision	Health Care FSA	Dependent Care FSA	Employee Group Life, AD&D and Disability Coverage
X. Judgement, Decree, or Order				
A. Order that Requires Coverage for the Child Under Employee's Plan	Employee may change election to provide coverage for the child. Though unclear, it appears that tag-along concepts may apply.	No change permitted.		
B. Order That Requires Former Spouse, or Other Individual to Provide Coverage for the Child	Employee may change election to cancel coverage for the child.		No change permitted.	
XI. Medicare or Medicaid				
A. Employee, Spouse, or Dependent Enrolled in Employer's Accident or Health Plan Becomes Entitled to Medicare or Medicaid (other than coverage solely for pediatric vaccines)	Unlikely that employee can elect to drop dental or vision coverage; presumably, employee must retain coverage.	Employee may apparently decrease or revoke election or increase election if Healthcare FSA is dropped due to Medicare/Medicaid and prior employer coverage was more comprehensive.	No change permitted.	
B. Employee, Spouse, or Dependent Loses Eligibility for Medicare or Medicaid (other than coverage solely for pediatric vaccines)	Unlikely that employee can elect to add dental or vision coverage; presumably, employee cannot.	Employee may apparently increase or decrease or revoke election where employer plan elected due to loss of eligibility for Medicare/ Medicaid and employer coverage is more comprehensive than Medicare/ Medicaid	No change permitted.	

IF YOU HAVE QUESTIONS ABOUT…	CALL…	ON THE WEB…
Benefits Office	805-564-5400	Benefits SharePoint
Dental Benefits		
• Delta DPO Plan	888-335-8227	www.deltadentalins.com
• DeltaCare HMO	800-422-4234	www.deltadentalins.com
Vision Benefits		
• Vision Service Plan	800-877-7195	www.vsp.com
Flexible Spending Accounts		
• WEX (formally Discovery Benefits)	866-451-3399	www.discoverybenefits.com
Employee Assistance Program (EAP)		
• OptumHealth	866-828-6049	www.liveandworkwell.com Passcode: 12605
Life and AD&D Insurance		
• Hartford Life & Accident Insurance Company	888-563-1124	www.thehartfordatwork.com
Disability Insurance		
• Hartford Life & Accident Insurance Company	800-289-9140	
• State Disability Insurance (SDI)	800-480-3287	www.edd.ca.gov/disability/
COBRA		
• Benefit Coordinators Corporation	800-685-6100	

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