

2020



EMPLOYEE
BENEFITS
GUIDE



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

Please see page 35 for more details.

The information in this brochure is a general outline of the benefits offered under the City of Oxnard's benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

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Introduction

Each year Open Enrollment provides you an opportunity to change plans and modify dependent coverage. Your election deductions begin in January and will remain in effect through the plan year (January 1, 2020 – December 31, 2020) for all of your benefits.

NOTE: If your eligibility changes during the year you must notify Human Resources within 60 days of the qualifying event. A list of qualifying events can be found on page 9 in this guide.

The grid below shows the period of time plan benefits accumulate and when premium rates are effective.

Before you meet with your American Fidelity Representative, take time to evaluate your current coverage and decide how well it serves the needs of you and your family.

Important Dates to Remember

Your Open Enrollment Dates are

**September 9, 2019 –
October 4, 2019**

Your Plan Year is

**January 1, 2020 –
December 31, 2020**

Important Points To Consider

- Figure an estimate of out-of-pocket medical expenses. Remember that over-the-counter drugs and medicines now require a prescription to be reimbursed.
- Figure an estimate of child care expenses.
- Review your beneficiaries.
- Review American Fidelity's options of portable insurance plans that you can keep if your employment changes.
- Evaluate your need for life insurance.
- Consider increasing your Disability Income Insurance policy amount to match your current salary.



Introduction (continued)

Health insurance is one of the most critical benefits offered by the City of Oxnard. A major illness or injury could be financially devastating without adequate insurance. Even the cost of treatment of minor conditions can be prohibitive. With this in mind, the benefit program is designed exclusively to meet the health care needs of you and your family.

Depending on where you live, your personal preference regarding physician choice and type of health care environment you prefer, you may choose the plan that is most suitable for you and your family members.

The benefit choices you make when you and your dependent(s) enroll will remain in place for the calendar year unless your spouse or domestic partner experiences a loss in coverage, or you experience a change in family status (e.g., marriage, divorce, or legal separation, birth, adoption, death or spousal change). You will need to contact the Human Resources Department and return your enrollment forms within 60 days of your status change in order to enroll into medical coverage.

If you are a benefits-eligible employee, you may enroll or change your medical carrier/plan, as well as add any eligible dependents not previously enrolled under your coverage.

In order to enroll a spouse, you will need to provide a copy of your marriage license issued by the state or country in which you were married. To enroll a domestic partner, you will need to provide a copy of your declaration of domestic partnership certificate issued by the state in which your domestic partnership was entered. If you wish to enroll dependent children, a copy of the birth certificate issued by the state, adoption papers, or proof of legal guardianship is required.

Your dependents are defined as:

- Legally married spouse
- Registered domestic partner
- **Children to age 26:**
 - Natural
 - Step-children
 - Children of a registered domestic partner
 - Legally adopted
 - Disabled adult child over age 26.

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

Important Notice

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

Introduction (continued)

Benefit Choices

The City recognizes that your benefits are an important part of the reason you choose to work here. The City provides high quality benefits at a reasonable cost to you. You can choose between different medical plans to meet your individual and family needs. Since you have some choices to make, it is important to understand the various programs. That is why this Guide is being provided for you. Benefits provided by the City for eligible employees include a choice of CalPERS medical plans, dental plans, a vision plan, group life insurance coverage, group disability and optional voluntary benefits.

Benefits will begin the 1st of the month following the receipt of your enrollment by the Health Benefits Officer.

Any questions you may have regarding the enclosed information can be referred to the corresponding representative on the contact information sheet or the health benefits directory.

During open enrollment, if you are a benefit eligible employee, you may enroll or change your medical carrier/plan, as well as add any eligible dependents not previously enrolled under your coverage.



Contact Information

Employee Benefits Program	Benefits Representative	Contact Information
Risk & Benefits Administration	Mike More Human Resources Manager	805.385.7480 mike.more@oxnard.org
COBRA	Charlie Lam Human Resources Technician	805.385.7473 charlie.lam@oxnard.org
• Medical	See Health Plan Directory on Page 12	
• Dental (PPO)	Delta Dental	800.632.8555 www.deltadentalins.com
• Dental (DHMO)	Cigna	800.244.6224 www.mycigna.com
• Vision	EyeMed	866.723.0513 www.eyemed.com
Flex Spending Accounts and Additional Insurances	American Fidelity	800.662.1113 www.americanfidelity.com
Life Insurance Etc.		
• Short Term Disability	The Standard	800.368.2859 Fax 800.378.6053
• Long Term Disability	The Standard	800.368.1135 Fax 800.378.6053
• Life Claims	The Standard	800.628.8600 Fax 971.321.6808
Employee Assistance Program	Empathia	800.367.7474 www.mylifematters.com passcode: coe
Fair Employment & Housing Act (FEHA)	Charlie Lam Human Resources Technician	805.385.7473 charlie.lam@oxnard.org
Workers Compensation	Celsa Moncayo-Reid Sr. Human Resources Coordinator	805.385.7458 celsa.moncayo@oxnard.org
Family Medical Leave Act (FMLA)	Charlie Lam Human Resources Technician	805.385.7473 charlie.lam@oxnard.org
Retirement (PERS)	Charlie Lam Human Resources Technician	805.385.7473 charlie.lam@oxnard.org

Benefit Information can be located at:
www.benefitbridge.com/oxnard

Section 125 Cafeteria Plan

Save Money with a Section 125 Plan

If there was a program available that could dramatically save money on your taxes, would you take advantage of it? That's exactly what the Section 125 Plan does – reduces your taxes and increases your spendable income! Plus, the Plan is available to you at no cost and you're already eligible, all you have to do is enroll.

The Plan works like this: You are allowed to deduct needed benefits from gross earnings before taxes are computed. This means that current after-tax expenses, such as insurance products and benefits, can be paid for with pre-tax dollars.

The advantage of this Plan is simple: The eligible premiums you pay under the Plan are paid on a pre-tax basis. You could be on your way to increased savings, just by signing up and taking advantage of this Plan!

Benefits Eligible

- Group Medical, Dental and Vision Insurance
- Accident Insurance
- Cancer Insurance
- Flexible Spending Accounts

How Can This Plan Help Me?

The sample paycheck below shows the benefits under the Section 125 Plan compared to benefits outside of the Plan. In this example, the employee gained \$55 more spendable income per month!

Pre-Tax Example		After-Tax Example
\$1,500	Monthly Gross Salary	\$1,500
(\$150)	Pre-Tax Medical Insurance	\$0.00
(\$25)	Pre-Tax Disability Insurance	\$0.00
(\$2,500)	Pre-Tax Accident Insurance	\$0.00
\$1,300	Adjusted Monthly Gross Salary	\$1,500
(\$260)	Estimated Federal Tax (20%)	(\$300)
(\$99)	Estimated FICA (7.65%)	(\$115)
\$0.00	After-Tax Medical Insurance	(\$150)
\$0.00	After-Tax Disability Insurance	(\$25)
\$0.00	After-Tax Accident Insurance	(\$25)
\$941	TAKE-HOME PAY	\$885

Taxes are a sample average of State, Federal and FICA taxes. Your own average tax rate may vary.



How to Enroll

The City is providing every employee with an opportunity to understand their employee benefits, ask questions unique to their situation, and enroll in benefits. These include group meetings and one-on-one on-site enrollments. Your enrollment options will be as follows:

Option 1

Online Enrollment on BenefitBridge

Self enroll at www.benefitbridge.com/oxnard

You have the ability to make changes via BenefitBridge beginning Monday September 9, 2019 through Friday, October 4, 2019. No changes will be allowed after this date.

Option 2

Enroll On-Site/One-on-One Benefit Review

On-site enrollment counselors will be available to assist you with the enrollment process. This allows you the opportunity to ask unique questions regarding your benefit options, in a confidential and private setting.

During your One-on-One Benefit Review, you can learn more about or enroll in the following:

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Group Life Insurance
- Term Life Insurance
- Disability Income Insurance
- Flexible Spending Accounts
- Cancer Insurance
- Accident Only Insurance
- Group Critical Illness



Eligibility and Enrollment

Who Is Eligible for the CalPERS Health Program?

Employees

Eligibility is based on tenure and time base of your qualifying appointment. You must work at least half-time and have a permanent appointment or a "limited term" appointment with a duration of more than six months. If you are a temporary or variable-hour employee, you may be eligible for health coverage due to new provisions in the Public Employee Medical and Hospital Care Act (PEMHCA) that help large contracting employers meet ACA requirements. To check if you meet the expanded eligibility criteria, contact your employer.

Family Members

The terms "family member" and "dependent" are used interchangeably. Eligible family members include:

- Spouse
- Registered domestic partner
- Children (natural, adopted, domestic partner's, or step) up to age 26
- Children, up to age 26, if the employee or annuitant has assumed a parent-child relationship and is considered the primary care parent
- Certified disabled dependent children age 26 and older

Who Is Not Eligible for the CalPERS Health Program?

Ineligible Employees

- Those working less than half time
- Those whose appointment lasts less than six months
- Those whose job classification is "Limited-Term/Intermittent" (seasonal or temporary)
- Those classified as "Permanent-Intermittent" who do not meet the hour requirements within the control period

Ineligible Family Members

- Former spouses/former registered domestic partners
- Children age 26 and older
- Disabled children over age 26 who were never enrolled or who were deleted from coverage
- Children of a former spouse/former registered domestic partner
- Grandparents
- Parents

Do Not Enroll Ineligible Family Members

It is against the law to enroll ineligible family members. If you do so, CalPERS will retroactively cancel the enrollment and you may have to pay all costs incurred by the ineligible person from the date the coverage began.

Where to Get Help With Your Health Benefits Enrollment

If you are an active employee, please refer to BenefitBridge to make all health benefit enrollment changes. If you have additional questions you may contact your Health Benefits Officer located in your Human Resources Department

Once you retire, CalPERS becomes your Health Benefits Officer. As a retiree, you may make changes to your health plan in any of the following ways:

- **Online through myCalPERS during Open Enrollment at:**
my.calpers.ca.gov
- **By writing to CalPERS at:**
P.O. Box 942715, Sacramento, CA 94229-2715
- **By calling CalPERS toll free at:**
888.CalPERS (or 888.225.7377).

For general information about health benefits, go to the CalPERS website at www.calpers.ca.gov.

* The Affordable Care Act has provisions which expand eligibility criteria for certain variable-hour employees. For additional information, please contact your employer.

Eligibility and Enrollment (continued)

Spouse

You may add your spouse to your health plan within 60 days of your marriage. You are required to provide a copy of the marriage certificate and the spouse's Social Security Number and Medicare card (if applicable). Your spouse's coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

Registered Domestic Partner

You may add your registered domestic partner to your health plan within 60 days of registration of the domestic partnership. The coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Enrollment Form.

To add a domestic partner to your health plan, you must register your domestic partnership through the California Secretary of State's Office or equivalent office from another state. Upon registration, that office will provide you with a Certificate of Registered Domestic Partnership.

CalPERS requires that you submit a copy of the Certificate of Registered Domestic Partnership and other information as may be required.

Two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring and who are not married to someone else or a member of another domestic partnership and not related by blood in a way that would prevent them from being married are eligible to register with the Secretary of State. For more information about domestic partnership registration, visit the Secretary of State's website at <https://www.sos.ca.gov/registries/domestic-partners-registry/>.

Children

Natural-born, adopted, domestic partners, and stepchildren who are under age 26 may be added to your health plan, as outlined below:

- Newborn children should be added within 60 days of birth. Coverage is effective from the date of birth.
- Newly adopted children should be added within 60 days of physical custody. Coverage is effective from the date physical custody is obtained.
- Stepchildren or a domestic partner's children under age 26 can be added within 60 days after the date of your marriage or registration of your domestic partnership. The coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

Disabled Children Over Age 26

A child age 26 and over who is incapable of self-support because of a mental or physical condition may be eligible for enrollment. The disability must have existed prior to reaching age 26 and continuously since age 26, as certified by a licensed physician. You are required to complete and submit the Member Questionnaire for the CalPERS Disabled Dependent Benefit form, and the physician must complete and submit a Medical Report for the CalPERS Disabled Dependent Benefit form for CalPERS approval. The initial certification of the Disabled Dependent must occur during one of the following two eligibility periods (whichever applies):

- Within 60 days before and ending 60 days after the child's 26th birthday (member and dependent currently enrolled), **or**
- Within 60 days of a newly eligible employee's initial enrollment in the CalPERS Health Program

Upon certification of eligibility, the dependent's coverage must be continuous and without lapse. You will be required to submit an updated questionnaire and medical report for re-certification periodically, upon request.

Note: If the disabled child has a Social Security approved disability, you must provide CalPERS with a copy of his or her Medicare card.

Eligibility and Enrollment (continued)

Life Changes and Their Impact on Benefits

Outside of the annual open enrollment period, an employee may change an enrollment election (i.e., add or delete dependents, change level of coverage) only if there has been a “major life event.”

Name or Address Changes

If you move or change your name or contact information for any reason, including Marriage or Divorce, you must change your name through your employer. That way you will receive all your benefit information in a timely manner.

Health Benefits Coverage

Since you must choose a CalPERS health plan that provides coverage in your work or home ZIP code, a change in your address could mean you have to change plans. You can use our Health Plan Search by ZIP Code on line service to see what plans are available in your new ZIP code.

Marriage

Retirement Impact – Your marriage revokes a designation you may have on file. In most instances, you must be married for at least one year prior to your retirement date for survivor benefits to be payable to your spouse. Review your beneficiary designation. If you need to make changes, log on to BenefitBridge and click on the “Life Events” button.

Health Benefits Coverage – Contact Human Resources as soon as possible to add your new spouse and any stepchildren to your health coverage. Your employer will need a copy of your marriage certificate and new spouse’s Social Security number, as well as birth certificates and social security cards for step children.

Divorce

Retirement Impact – Your CalPERS benefits are considered community property under California law. To see how this may impact your benefits, review Community Property (PUB38AI PDF) or CalPERS at 888.225.7377. Your dissolution of marriage revokes a designation you may currently have on file with CalPERS. Review your beneficiary designation. If you need to make changes, log in to your my CalPERS account to make changes online or complete the appropriate designation form.

To see how this may impact your benefits, review Community Property (PUB38AI PDF) or contact CalPERS at 888.225.7377.

Registered Domestic Partnership

To find out more about registering a domestic partner, visit the Secretary of State website.

Retirement Impact – Your domestic partnership revokes a designation you may have on file. Review your beneficiary designation. If you need to make changes, log on to BenefitBridge.



Eligibility and Enrollment (continued)

Additional Enrollment Opportunities

New employees and their dependents may initially enroll in a CalPERS health plan as indicated in the previous sections. Additional enrollment options and guidelines are described below.

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) to improve portability and continuity of health insurance coverage in the group insurance markets. HIPAA requirements for CalPERS took effect in 1998. HIPAA offers two provisions for employees and family members to enroll in CalPERS health plans outside of the initial enrollment period and the Open Enrollment period.

Special Enrollment

Special Enrollment refers to certain types of enrollment after your initial enrollment, but outside of the Open Enrollment period. You may need Special Enrollment under the following circumstances:

You lose other health coverage: If you initially declined (or canceled) enrollment for yourself or your dependents (including your spouse) because you had other private or CalPERS health coverage at that time, you may be able to enroll in a CalPERS health plan if the other coverage involuntarily ends. To qualify, you will need to request enrollment within 60 days after the other coverage ends and provide proof that the other coverage has ended.

You have new family members: When you enroll, you must enroll yourself or yourself and all eligible family members. If you later have a new dependent as a result of marriage, domestic partnership registration, birth, change of custody, adoption, or placement for adoption, you may enroll yourself and all eligible dependents within 60 days of that event.

The effective date for a Special Enrollment is the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

Late Enrollment

If you decline or cancel enrollment for yourself or your dependents and the Special Enrollment exceptions do not apply, your right to enroll (or add dependents) will be limited. You will either have to wait for a 90-day period or until the next CalPERS Open Enrollment period. The earliest effective date of enrollment will be the first of the month following the 90-day waiting period or the January 1 following the Open Enrollment period.



Eligibility and Enrollment (continued)

City of Oxnard Online Benefits Enrollment is easy with BenefitBridge!



Need Help?

For all questions related to your benefits, please contact your employer's benefits administrator. For BenefitBridge technical assistance **only**, please contact BenefitBridge Customer Care at 800.814.1862; Mon – Fri, 8:00 a.m. – 5:00 p.m., PST or email benefitbridge@keenan.com.

Here's what you can do on BenefitBridge:

- View Current Plan Year Benefits
- Compare Plan Options
- Enroll in Benefits
- Resource Center: Health Insurance Basics, Medicare, Glossary, Media Resources
- Add or Remove Dependents/Beneficiaries
- Message Center
- Update My Account Info
- Available 24/7 via the Internet

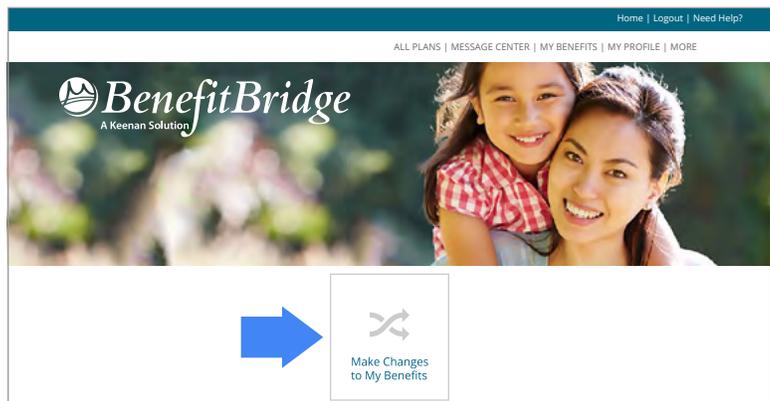
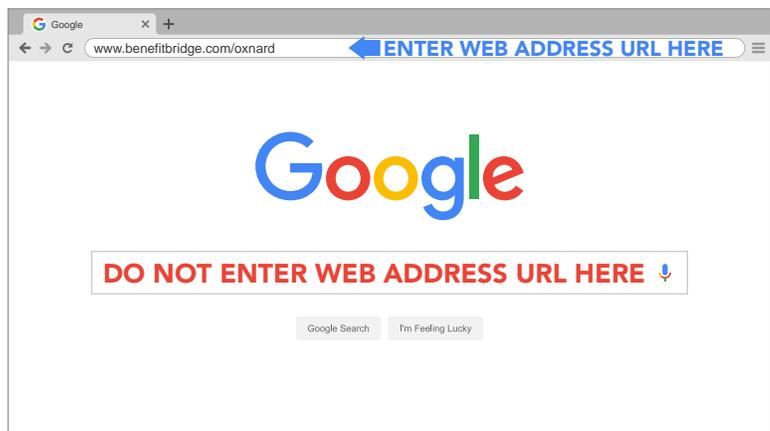
Registration and Login

Already have login credentials?

1. Login to **BenefitBridge** at www.benefitbridge.com/oxnard
2. Forgot your Username or Password? Click on **"Forgot Username/Password?"**
3. Please add or update your email address to receive an email confirmation of your enrollment approval.

Need to create login credentials?

1. In the **address bar**, type www.benefitbridge.com/oxnard (**Not in the Google, Yahoo, Bing, etc. search engine field**)
2. Click the **Enter** key, then follow the instructions below to register:
 - **STEP 1:**
Select **"Register"** to **Create an Account**
 - **STEP 2:**
Create a **Username** and **Password**
 - **STEP 3:**
Select **"Continue"** to access **BenefitBridge**



Enrolling in Benefits

Access your enrollment via the **"Make Changes to My Benefits"** button

2020 Summary of Benefits and Coverage Notice

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

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

Anthem Blue Cross HMO (Select, Traditional)

855.839.4524

www.anthem.com/ca/calpershmo

Blue Shield of California

800.334.5847

www.blueshieldca.com/calpers

California Association of Highway Patrolmen**

800.734.2247

www.thecahp.org

California Correctional Peace Officers Association**

800.257.6213

www.ccpoa.btfo.org

Health Net of California

888.926.4921

www.healthnet.com/calpers

Kaiser Permanente

800.464.4000

www.kp.org/calpers

Peace Officers Research Association of California**

800.288.6928

<http://ibt.porac.org>

PERS Select, PERS Choice, and PERSCare

877.737.7776

www.anthem.com/ca/calpers

Sharp Health Plan

855.995.5004

www.sharphealthplan.com/calpers

United Healthcare

877.359.3714

www.uhc.com/calpers

Western Health Advantage

888.942.7377

www.westernhealth.com/calpers

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

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

Considering Your Health Plan Choices

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

Selecting a health plan for yourself and your family is one of the most important decisions you will make. This decision involves balancing the cost of each plan, along with other features, such as access to doctors and hospitals, pharmacy services, and special programs for managing specific medical conditions. Choosing the right plan ensures that you receive the health benefits and services that matter to you.

If you are a new CalPERS member or you are considering changing your health plan during Open Enrollment, you will need to make two related decisions:

- Which health plan is best for you and your family?
- Which doctors and hospitals do you want to provide your care?

The combination of health plan and providers that is right for you depends on a variety of factors, such as whether you prefer a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO); your premium and out-of-pocket costs; and whether you want to have access to specific doctors and hospitals.

We realize that comparing health plan benefits, features, and costs can be complicated. This section provides information that can simplify your decision making process. As you begin that process, the following are some questions you should ask:

- Do you prefer to receive your health care from an HMO or PPO? Your preference will impact the plans available to you, your access to health care providers, and how much you pay for certain services. See the chart on the next page for a summary of the differences among plan types¹.
- What are the costs (premiums, co-payments, deductibles, and coinsurance)?
- Does the plan provide access to the doctors and hospitals you want? Contact health plans directly for this information. See the "Health Plan Directory"

1. Note that in a few counties where access to HMOs is limited, a third option. Exclusive Provider Organization (EPO). is available. An EPO provides benefits similar to an HMO with some PPO features.



Understanding How CalPERS Health Plans Work

The following chart will help you understand some important differences among health plan types.

Features	HMO	PPO
Accessing health care providers	<ul style="list-style-type: none"> Contracts with providers (doctors, medical groups, hospitals, labs, pharmacies, etc.) to provide you services at a fixed price 	<ul style="list-style-type: none"> Gives you access to a network of health care providers (doctors, hospitals, labs, pharmacies, etc.) known as preferred providers
Selecting a primary care physician (PCP)	<ul style="list-style-type: none"> Most HMOs require you to select a PCP who will work with you to manage your health care needs¹ 	<ul style="list-style-type: none"> Does not require you to select a PCP
Seeing a specialist	<ul style="list-style-type: none"> Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests 	<ul style="list-style-type: none"> Allows you access to many types of services without receiving a referral or advance approval
Obtaining care	<ul style="list-style-type: none"> Generally requires you to obtain care from providers who are a part of the plan network Requires you to pay the total cost of services if you obtain care outside the HMO's provider network without a referral from the health plan (except for emergency and urgent care services) 	<ul style="list-style-type: none"> Encourages you to seek services from preferred providers to ensure your coinsurance and co-payments are counted toward your calendar year out-of-pocket maximums² Allows you the option of seeing non-preferred providers, but requires you to pay a higher percentage of the bill³
Paying for services	<ul style="list-style-type: none"> Requires you to make a small co-payment for most services 	<ul style="list-style-type: none"> Limits the amount preferred providers can charge you for services Considers the PPO plan payment plus any deductibles and co-payments you make as payment in full for services rendered by a preferred provider

1. Your PCP may be part of a medical group that has contracted with the health plan to perform some functions, including treatment authorization, referrals to specialists, and initial grievance processing.
2. Once you meet your annual deductible and co-insurance, the plan pays 100 percent of medical claims for the remainder of the calendar year; however, you will continue to be responsible for co-payments for physician office visits, pharmacy, and other services, up to the annual out-of-pocket maximum.
3. Non-preferred providers have not contracted with the health plan; therefore, you will be responsible for paying any applicable member deductibles or coinsurance, plus any amount in excess of the allowed amount



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

2020 Premiums/Cafeteria

Medical	2019 Biweekly Deductions			2020 Biweekly Deductions		
	Single	2-Party	Family	Single	2-Party	Family
Medical HMO Plans						
• Anthem Select HMO	\$226.65	\$516.06	\$689.71	\$237.71	\$539.58	\$720.69
• Anthem Traditional HMO	\$342.68	\$748.14	\$991.41	\$367.36	\$798.88	\$1,057.79
• Blue Shield Access+	\$246.35	\$555.46	\$740.93	\$355.79	\$775.73	\$1,027.69
• HealthNet SmartCare <i>(must reside in LA County)</i>	\$206.89	\$476.56	\$638.35	\$267.81	\$599.78	\$798.96
• HealthNet Salud y Mas <i>(must reside in LA County)</i>	\$101.77	\$266.31	\$365.03	\$136.68	\$337.51	\$458.01
• Kaiser Permanente	\$222.76	\$508.28	\$679.60	\$233.65	\$531.45	\$710.13
• United Healthcare	\$246.28	\$555.33	\$740.76	\$245.82	\$555.78	\$741.77
Medical PPO Plans						
• PERS Select	\$131.43	\$325.63	\$442.15	\$144.25	\$352.65	\$477.69
• PERS Choice	\$239.31	\$541.38	\$722.63	\$275.67	\$615.49	\$819.38
• PERSCare	\$326.67	\$716.10	\$949.77	\$391.23	\$846.61	\$1,119.84
• PORAC <i>(Police Safety Only)</i>	\$294.46	\$686.31	\$895.38	\$281.54	\$627.69	\$840.46

Important Notes:

- Starting 1/01/2020 Health Plan Rates for Ventura County will no longer be grouped with L.A. County as they were in previous years. Plan rates outside of Ventura County will differ and may be higher or lower based on the Regional Rates set by CalPERS.
- Employees who enroll in a health plan that is deemed to be outside of the Ventura County by CalPERS will be responsible for the applicable cost differential.
- Employees who reside in Santa Barbara County must use the Employer's (City of Oxnard) Zip Code if they wish to enroll in the Kaiser Permanente HMO Plan.
- Premiums have been reduced by the monthly PEMHCA contributions of \$139.

Dental/Vision	2019 Biweekly Deductions		2020 Biweekly Deductions	
	Premium		Premium	
Dental				
• Delta Dental PPO	\$50.13		\$51.13	
• Cigna Dental HMO	\$13.57		\$14.25	
Vision				
• EyeMed Vision	\$6.86		\$6.86	

Biweekly Medical Cafeteria Dollars (26 Pay Periods)*

Group	Title	Amount	If Waived
IAFF	International Association of Fire Fighters	\$509.08 (\$1,103.00/month)	\$416.77 (\$903.00/Month)
IUOE	International Union of Operating Engineers	\$217.08 (\$470.34/month)	\$217.08 (\$470.34/month)
OMMA	Oxnard Mid Managers Association	\$200.00 (\$433.33/month)	\$200.00 (\$433.33/month)
OPOA	Oxnard Peace Officers Association	\$527.54 (\$1,143.00/month)	\$435.23 (\$943.00/Month)
OPSMA	Oxnard Public Safety Management Association	\$527.54 (\$1,143.00/month)	\$435.23 (\$943.00/Month)
SEIU	Service Employees International Union	\$332.01 (\$719.36/month)	\$332.01 (\$719.36/month)
Confidential	Confidential/Non Management	\$332.01 (\$719.36/month)	\$332.01 (\$719.36/month)
Confidential	Unrepresented Executive/Mid Management/Councilmembers	\$242.31 (\$525.01/month)	\$242.31 (\$525.01/month)

* Health Cafeteria amount current as of August 2019. Subject to change based on the City Council's ratification of employee agreements.

Biweekly Dental Cafeteria Dollars (26 Pay Periods)

Group	Title	Amount
SEIU	Service Employees International Union	\$34.25 (\$74.21/month)
Other Covered Unions	IAFF, IUOE, OMMA, OPOA, OPSMA, Confidential	\$30.83 (\$66.80/month)

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Medical – 2020 CalPERS HMO Plans

For more information on CalPERS please contact Human Resources, or visit the CalPERS website: calpers.ca.gov.

Benefits	Anthem Blue Cross	Blue Shield	Health Net	Kaiser Permanente*	UnitedHealthcare SignatureValue Alliance
	Select HMO & Traditional HMO	Access+ HMO	Salud y Más & SmartCare		
Calendar Year Deductible					
• Individual	N/A	N/A	N/A	N/A	N/A
• Family	N/A	N/A	N/A	N/A	N/A
Maximum Calendar Year Co-pay or Co-insurance (excluding pharmacy)					
• Individual	\$1,500 (co-pay)	\$1,500 (co-pay)	\$1,500 (co-pay)	\$1,500 (co-pay)	\$1,500 (co-pay)
• Family	\$3,000 (co-pay)	\$3,000 (co-pay)	\$3,000 (co-pay)	\$3,000 (co-pay)	\$3,000 (co-pay)
Hospital (including Mental Health and Substance Abuse)					
• Deductible (per admission)	N/A	N/A	N/A	N/A	N/A
• Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient Facility/Surgery Services	No Charge	No Charge	No Charge	\$15	No Charge
Emergency Services					
• Emergency Room Deductible	N/A	N/A	N/A	N/A	N/A
• Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	\$50	\$50	\$50	\$50	\$50
• Non-Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	\$50	\$50	\$50	\$50	\$50
Physician Services (including Mental Health and Substance Abuse)					
• Office Visits (co-pay for each service provided)	\$15	\$15	\$15	\$15	\$15
• Inpatient Visits	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient Visits	\$15	\$15	\$15	\$15	\$15
• Urgent Care Visits	\$15	\$15	\$15	\$15	\$15
• Preventive Services	No Charge	No Charge	No Charge	No Charge	No Charge
• Surgery/Anesthesia	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostic X-Ray/Lab					
	No Charge	No Charge	No Charge	No Charge	No Charge

* Kaiser is not an option for Santa Barbara Residents unless you are using the City of Oxnard address.

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Medical – 2020 CalPERS HMO Plans (continued)

For more information on CalPERS please contact Human Resources, or visit the CalPERS website: calpers.ca.gov.

Benefits	Anthem Blue Cross	Blue Shield	Health Net	Kaiser Permanente*	UnitedHealthcare SignatureValue Alliance
	Select HMO & Traditional HMO	Access+ HMO	Salud y Más & SmartCare		
Prescription Drugs					
• Deductible	N/A	N/A	N/A	N/A	N/A
• Retail Pharmacy <i>(not to exceed 30-day supply)</i>	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Generic: \$5 Brand: \$20	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50
• Retail Preferred Pharmacy Maintenance Medications	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	N/A	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100
• Mail Order Pharmacy Program <i>(not to exceed 90-day supply for maintenance drugs)</i>	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand: \$40 <i>(31-100 day supply)</i>	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100
• Mail order maximum co-payment per person per calendar year	\$1,000	\$1,000	\$1,000	N/A	\$1,000
Durable Medical Equipment					
	No Charge	No Charge	No Charge	No Charge	No Charge
Infertility Testing/Treatment					
	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges
Occupational /Physical /Speech Therapy					
• Inpatient <i>(hospital or skilled nursing facility)</i>	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient <i>(office and home visits)</i>	\$15	\$15	\$15	\$15	\$15
Diabetes Services					
• Glucose monitors	No Charge	No Charge	No Charge	No Charge	No Charge
• Self-management training	\$15	\$15	\$15	\$15	\$15
Acupuncture (Acupuncture/chiropractic; combined 20 visits per calendar year)					
	\$15/visit	\$15/visit	\$15/visit	\$15/visit	\$15/visit
Chiropractic Acupuncture/chiropractic; combined 20 visits per calendar year)					
	\$15/visit	\$15/visit	\$15/visit	\$15/visit	\$15/visit

* Kaiser is not an option for Santa Barbara Residents unless you are using the City of Oxnard address.

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Medical – 2020 CalPERS PPO Plans

For more information on CalPERS please contact Human Resources, or visit the CalPERS website: calpers.ca.gov.

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

- Incentives available to reduce individual deductible (max. \$500) or family deductible (max. \$1,000) include:** getting a biometric screening (\$100 credit); receiving a flu shot (\$100 credit); getting a non-smoking certification (\$100 credit); getting a virtual second opinion (\$100 credit); and getting a condition care certification (\$100 credit).
- Coinsurance waived for deliveries if enrolled in Future Moms Program.

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Medical – 2020 CalPERS PPO Plans (continued)

For more information on CalPERS please contact Human Resources, or visit the CalPERS website: calpers.ca.gov.

Benefits	PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Physician Services (including Mental Health and Substance Abuse)								
• Office Visits (co-pay for each service provided)	\$35 ^{1,2}	40%	\$20 ²	40%	\$20 ²	40%	\$10/\$35 ²	20%
• Inpatient Visits	20%	40%	20%	40%	10%	40%	20%	20%
• Outpatient Visits	\$20	40%	\$20	40%	\$20	40%	20%	20%
• Urgent Care Visits	\$35	40%	\$35	40%	\$35	40%	\$35	20%
• Preventive Services	No Charge	40%	No Charge	40%	No Charge	40%	No Charge	No Charge
• Surgery/Anesthesia	20%	40%	20%	40%	10%	40%	20%	20%
Diagnostic X-Ray/Lab								
	20%	40%	20%	40%	10%	40%	20%	20%
Prescription Drugs								
• Deductible	N/A		N/A		N/A		N/A	
• Retail Pharmacy (not to exceed 30-day supply)	Generic: \$5 Formulary: \$20 Non-Formulary: \$50		Generic: \$5 Formulary: \$20 Non-Formulary: \$50		Generic: \$5 Formulary: \$20 Non-Formulary: \$50		Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$45 Compound: \$45	
• Retail Preferred Pharmacy Maintenance Medications	Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		N/A	
• Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$20 Brand Formulary: \$40 Non-Formulary: \$75	N/A
• Mail order maximum co-payment per person per calendar year	\$1,000		\$1,000		\$1,000		N/A	

1. Reduced to \$10 if enrolled with personal doctor.
2. \$35 for specialist visit.

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Medical – 2020 CalPERS PPO Plans (continued)

For more information on CalPERS please contact Human Resources, or visit the CalPERS website: calpers.ca.gov.

Benefits	PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Durable Medical Equipment								
	20%	40%	20%	40%	10%	40%	20%	20%
	(pre-certification required for equipment)		(pre-certification required for equipment)		(pre-certification required for equipment \$1,000 or more)			
Infertility Testing/Treatment								
	Not Covered		Not Covered		Not Covered		50%	50%
Occupational/Physical/Speech Therapy								
• Inpatient (hospital or skilled nursing facility)	No Charge		No Charge		No Charge		\$20; Speech therapy: 10%	20%
• Outpatient (office and home visits)	20%	40%; Occupational therapy: 20%	20%	40%; Occupational therapy: 20%	10%	40%; Occupational therapy: 10%	\$20	20%
	(Pre-certification required for more than 24 visits)		(Pre-certification required for more than 24 visits)		(Pre-certification required for more than 24 visits)			
Diabetes Services								
• Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies	
• Self-management training	\$20	60%	\$20	60%	\$20	60%	\$20	60%
Acupuncture								
	\$15/visit	40%	\$15/visit	40%	\$15/visit	40%	\$20 (10% for all other services)	20%
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)			
Chiropractic								
	\$15/visit	40%	\$15/visit	40%	\$15/visit	40%	\$20 (up to 20 visits)	20%
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)			

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Dental Plans

When it comes to choosing a dental plan, you want benefits that fit the needs of you and your family. Delta PPO and Cigna Dental HMO both offer comprehensive dental coverage, quality care and excellent customer service. The City allows full-time and permanent part-time employee and their eligible dependents to elect from one of the two plan offerings.

Cigna DHMO

Cigna is our prepaid plan that features set copayments, no annual deductibles and no maximums for covered benefits. Enrollees must select a primary care dentist in the Cigna Dental network from whom they receive treatment as in a traditional dental HMO.

Delta Dental

Delta Dental, our preferred provider organization (PPO) plan, provides access to the largest PPO dentist network in the U.S. Delta Dental dentists agree to accept reduced fees for covered procedures when treating PPO patients. This means your out-of-pocket costs are usually lower when you visit a PPO dentist than when you visit a non-Delta Dental dentist, but you have the freedom to visit any licensed dentist, anywhere in the world.



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Dental Plans (continued)

Cigna Dental DHMO

With the Cigna DHMO Plan, you receive care from your assigned dentist and are informed of copay amounts ahead of time.

Plan Benefits	Cigna
General Plan Information	
• Annual Deductible	
– Individual	\$0
– Family	\$0
• Waived for Preventive	N/A
• Annual Plan Maximum	N/A
• Lifetime Orthodontia Plan Maximum	Up to Age 19 Children: \$980 Adults: \$1450
Diagnostic and Preventive Services	
• Diagnostic and Preventive	\$0 - \$50 copay
• Oral Exams	100% covered limited 4 per year
• Bitewing X-rays	100% covered
• Full Mouth X-rays	100% covered every 36 months
• Cleaning and Scaling	100% covered every six months
• Prophylaxis Treatments	100% covered every six months
• Fluoride Treatments	100% covered
• Space Maintainers	\$0 copay
• Sealants	\$0 copay
Basic Services	
• Basic	\$0 - \$225 copay
• Oral Surgery (<i>Extractions and Other Surgical Procedures</i>)	\$0 - \$250 copay
• Endodontic Treatment	\$0 - \$250 copay
• Periodontic Treatment	\$0 - \$195 copay
• Re-linings and Re-basings of Existing Removable Dentures	\$0 - \$50 copay
• Repair or Re-cementing of Crowns, Inlays, Onlays, Dentures or Bridgework	\$0 - \$150 copay
Major Services	
• Major	\$0 - \$200 copay
• Crowns, Jackets and Cast Restorations	\$0 - \$200 copay
• TMJ	\$240 per calendar year
• Prosthodontic Benefits (<i>Fixed Bridges, Partial/Complete Dentures</i>)	\$0 - \$200 copay
• Implants	\$0 - \$600

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Dental Plans (continued)

Delta Dental PPO

Although the percentages of Benefits are the same no matter which dentist you choose, your out-of-pocket expenses may be greater if you choose a Delta Dental PPO Dentist.

Plan Benefits	Delta Dental PPO	
	In-Network	Out-of-Network
General Plan Information		
• Annual Deductible		
– Individual	\$0	\$0
– Family	\$0	\$0
• Annual Plan Maximum	\$1,500	\$1,000
• Lifetime Orthodontia Plan Maximum	\$500	\$500
Diagnostic and Preventive Services		
• Diagnostic and Preventive	100%	100%
• Oral Exams	100%	100%
• Bitewing X-rays	100%	100%
• Full Mouth X-rays	100%	100%
• Cleaning and Scaling	100%	100%
• Prophylaxis Treatments	100%	100%
• Fluoride Treatments	100%	100%
• Space Maintainers	100%	100%
• Sealants	100%	100%
Basic Services		
• Basic	100%	100%
• Oral Surgery (<i>Extractions and Other Surgical Procedures</i>)	100%	100%
• Endodontic Treatment	100%	100%
• Periodontic Treatment	100%	100%
• Re-linings and Re-basings of Existing Removable Dentures	50%	50%
• Repair or Re-cementing of Crowns, Inlays, Onlays, or Bridgework	70 - 100%	70 - 100%
Major Services		
• Major	100%	100%
• Crowns, Jackets and Cast Restorations	100%	100%
• Prosthodontic Benefits (<i>Fixed Bridges, Partial/Complete Dentures</i>)	50%	50%
• Implants	50%	50%

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Vision Plans

The City offers a vision plan through EyeMed. The plan pays benefits and offers discounts for most vision care expenses you incur while covered by the plan, subject to the maximum amounts shown below. Vision coverage is available for full-time and permanent part-time employees and their eligible dependents. If you use EyeMed providers, your costs for most services and materials are limited to the applicable copays. To find more information on EyeMed or to locate a provider, please visit eyemed.com.

Plan Benefits	EyeMed	
	In-Network	Out-of-Network
General Plan Information		
• Exam	\$10 copay	Up to \$40 allowance
• Exam with Dilation as Necessary	\$10 copay	Up to \$40 allowance
• Retinal Imaging	Up to \$39	N/A
• Frames	\$0 copay; \$130 allowance 20% off balance over \$130	Up to \$91
Contact Lens fit and Follow-up <i>(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed)</i>		
• Standard Contact Lens Fit & Follow-Up	Up to \$55	N/A
• Premium Contact Lens Fit & Follow-Up	10% off retail	N/A
• Contact Lenses		
– Conventional	\$0 copay; \$130 allowance; 15% off balance over \$130	Up to \$130
– Disposable	\$0 copay; \$130 allowance; plus balance over \$130	Up to \$130
Benefit Frequency		
• Exam	12 months	12 months
• Lenses	12 months	12 months
• Frames	12 months	12 months
• Contacts <i>(in place of lenses)</i>	12 months	12 months
Covered Services		
• Single Vision Lens	Covered after copay	Up to \$30
• Bifocal Lens	Covered after copay	Up to \$50
• Trifocal Lenses	Covered after copay	Up to \$70
• Lenticular	Covered after copay	Up to \$70
• Standard Progressive	\$75 copay	Up to \$50
Lens Options		
• UV Coating	\$15	N/A
• Tint <i>(Solid and Gradient)</i>	\$15	N/A
• Scratch Resistance	\$15	N/A
• Basic Polycarbonate	\$40	N/A
• Standard Anti-Reflective	\$45	Not covered
• Other Add-Ons and Services	Discounts available - 20% off retail	Not covered
Contact Lens		
• Medically Necessary	100%	Up to \$210 allowance
• Elective	Up to \$130 allowance	Up to \$130 allowance
Other Services		
• Corrective Vision Services <i>(Laser Surgery)</i>	Discount available	
• Second Pair of Glasses	Discount available	

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Vision Plans (continued)

FREEDOM PASS

Supersize their savings



Any frame, any brand at any price point for no out-of-pocket expense – a special offer for your employees from Target® Optical and Sears® Optical.* Plus, members also get \$20 off their contacts purchase (and free shipping) from ContactsDirect.com.

HOW IT WORKS – SAVINGS ON FRAMES

Your employees will simply go to their local Target Optical or Sears Optical store, find their frame (ANY available frame!) and they'll incur no cost.* And that means they have the freedom to find a great frame that matches their style and personality, while keeping money in their pocket.

HOW IT WORKS – SAVINGS ON CONTACT LENSES

When members visit ContactsDirect.com to purchase contact lenses, they simply create an account and register their vision benefits. The \$20 savings will then automatically apply in their cart during checkout.

WHAT IT INCLUDES

With this special offer from Target Optical, Sears Optical and ContactsDirect, your employees can choose from a wide selection of frame and contact lens brands, including:



* A special offer from Target Optical and Sears Optical. Valid for each year of the initial contract term and in-store only at Target Optical and Sears Optical. Offer not valid at Sears Optical stores affiliated with US Vision. Member is still responsible for lenses, which are covered based on benefits outlined in the vision benefits and may include an additional copay. ** EyeMed analysis of business results, before and after offering Freedom Pass from Target Optical and Sears Optical, 2017.

WITH THE
FREEDOM PASS OFFER:**



Utilization goes up



Member out-of-pocket
costs go down

Vision Plans (continued)

SEE THE VALUE

 <p>Coach HC6091B</p>	Retail cost of Coach frame	\$230
	Member frame cost without Freedom Pass <small>(\$130 frame allowance + 20% standard additional discount)</small>	\$80
	Member cost with Freedom Pass	\$0
 <p>12 pack (6 month supply)</p>	Retail cost of Acuvue Oasys	\$144
	Member contact lens cost without Freedom Pass <small>(\$130 contact lens allowance)</small>	\$14
	Member cost with Freedom Pass	\$0

WHERE MEMBERS SAVE

Target Optical, Sears Optical and ContactDirect offer plenty of chances to use the Freedom Pass:

	Locations	Selection
	More than 350 nationwide	About 700 frames, per location
	Nearly 600 nationwide	About 900 frames, per location
	Always available online	Many top-selling contact lens brands



HELPING MEMBERS FEEL FREE

Freedom Pass makes it even better. The combination of great style, with a guarantee of no additional out-of-pocket cost on preferred, quality brands – it's a game changer.

– Internet services company, Scottsdale AZ

** on average

Give your employees more freedom than ever –
Contact your EyeMed rep or visit starthere.eyemed.com

S-1801-CB-79

Life and AD&D – Class 1 & 2

The Standard Life Insurance

The City currently pays 100% of your monthly insurance premium. Basic Life Insurance would help your family or beneficiary cover costs in your absence. AD&D insurance provides additional protection for your beneficiaries in the event of your accidental death or loss of a limb or eye sight.

Life insurance coverage will cease after termination of employment but conversion is an option.

Benefits at a Glance

	Class 1	Class 2
	All Full-Time Management, Confidential Management and OPSMA	All Regular Full-Time Employees Except Temporary or Seasonal Workers
Eligible Member	All employees or active participants working more than 30 or more hours per week	
Benefit Amount	1x Annual salary up to \$500,000	\$5,000
Guarantee Issue	\$300,000	\$5,000
Accelerated Death Benefit	80% of benefit not to exceed \$250,000	80% of benefit not to exceed \$4,000
Waiver of Premium	If you become totally disabled while active and insured before your 60th birthday, premium is waived. Proof of disability is required.	
Conversion	If you leave your job for any reason you may be able to change your group life coverage to an individual policy. You must apply for coverage by completing the request for Group Life Conversion form. For questions, please call 800.378.4668.	
Age reduction and exclusions	At age 70, amounts reduce to 50%	

Additional Supplemental Life Insurance is available at the employee’s cost. Please inquire within Human Resources/Benefits for further details.



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Voluntary Life and AD&D (Employee Paid)

The Standard

Benefits at a Glance

Eligible Member: All eligible employees working 30 or more hours per week.

Optional group term life insurance benefit amount:

- You may purchase minimum coverage in an amount equal to 1x annual salary or to a maximum of 3x annual salary, up to \$500,000.

Optional employee AD&D benefit amount:

- Same as Voluntary Life amount. Optional AD&D coverage is included for all employees who elect Optional Voluntary Coverage.
- Optional Accidental Death and Dismemberment Insurance pays a benefit to your beneficiary if your death is caused by an accident. You may also get part of this benefit if an accident results in the loss of sight, a limb, certain fingers or toes, speech, hearing or certain types of paralysis (not able to move part of your body).

Optional life coverage for your family:

- You may also choose additional life coverage for your spouse and your children.
- You may purchase coverage for your spouse in increments of \$5,000 up to \$250,000.

- You may purchase coverage for your children (15 days – age 26 years) in increments of \$1,000 up to \$10,000.
- Any election will require Evidence of Insurability form to be completed and approved by The Standard.
- Dependents coverage may not exceed 100% of the employee's benefit amount.

Waiver of Premium: If you become totally disabled while active and insured before your 60th birthday, premium is waived.

Portability: If you leave employment for reasons other than retirement or disability, this feature allows you to take your optional life.

Age Reduction and Exclusions:

- At age 70 amount reduces to 50%
- Spouse coverage terminated at age 70

Guaranteed Issue:

- For You:** Up to the lesser of 3 times your annual salary or \$300,000
- For Your Spouse:** Up to \$50,000

Disability

All Eligible Management, Confidential Management, and OPSMA

Short Term Disability (STD)

This benefit allows you to continue receiving a percentage of your salary in the event you become ill or injured and cannot perform your regularly assigned duties. This benefit is paid for by the City of Oxnard.

You must be working a minimum of 30 hours a week.

- | | |
|--|--|
| <ul style="list-style-type: none">Waiting Period:
90 daysBenefit Period:
SSNRA* | <ul style="list-style-type: none">Benefit Percentage:
66 2/3 with a maximum of \$1,384 per week |
|--|--|

Long Term Disability (LTD)

The City of Oxnard offers an LTD benefit through The Standard. Employees are able to receive the lesser of 66 2/3% of your basic monthly earnings, up to a maximum of \$6,000 per month.

You must be working a minimum of 30 hours a week.

- | | |
|---|--|
| <ul style="list-style-type: none">Waiting Period:
30 daysBenefit Period:
9 weeks | <ul style="list-style-type: none">Benefit Percentage:
66 2/3 with a maximum of \$1,384 per week |
|---|--|

* SSNRA stands for Social Security Normal Retirement Age. This means your normal retirement age under the Federal Social Security Act, as amended.

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

American Fidelity Flexible Spending Benefits (Section 125)

Health Flexible Spending Account (FSA)

A Health Flexible Spending Account (FSA) allows you to allocate money on a pre-tax basis for qualified medical expenses for you and your family. Qualified expenses include anything from copays, medical deductibles, prescriptions and much more.

The minimum amount you may contribute to a Health Flexible Spending Account for the plan year is \$150; the maximum is \$2,650 and up to \$5,000 for dependent care.

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

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

Your Section 125 Plan

Participating in your employer's Section 125 Plan helps reduce your tax and increase your spendable income. Many qualified benefit premiums you pay under the plan are paid on a pre-tax basis.

Benefits Available to You

Healthcare Flexible Spending Account (HCFSA): Health Flexible Spending Account (FSA) allows you to allocate money on a pre-tax basis to be used for qualified medical expenses for you and your family.

Dependent Care Account (DCA): Dependent flexible spending account allows you to set aside pre-tax dollars to reimburse yourself for eligible dependent care expenses.

Cancer Insurance*+: If you were unexpectedly faced with a cancer diagnosis, will your major medical insurance be enough? Limited Benefit Cancer Insurance may help. Benefit payments are made directly to you, allowing you to pay for expenses like copayments, hospital stays, and house and car payments.

Accident Only Insurance*+: Accidents are inevitable. Even though you can't always prepare for unforeseen events, you can plan ahead. A Limited Benefit Accident Only Insurance plan may help ease the impact on your finances. This plan pays benefits directly to you, helping you cover any unplanned medical expenses due to a covered accident.

Life Insurance*::** Ensuring your family is financially protected in the event of a loss is an important way of caring for their needs. Life Insurance can help. Securing a life insurance policy helps provide peace of mind knowing it will help take care of your family after you're gone.

Group Critical Illness Insurance*+:#: If you experience an event such as a heart attack or stroke, Limited Benefit Critical Illness Insurance may help. It pays a lump sum amount to help with expenses that may not be covered by major medical insurance - house payments, everyday expenses, lost income, and more.

Post-tax Benefits

Disability Income Insurance*: In the simplest of terms, this plan helps protect your income. Disability Income Insurance is designed to help protect you if you can't work due to a covered injury or sickness. It provides steady benefits to cover expenses, paying a percentage of your gross monthly earnings.

* These products may contain limitations, exclusions, and waiting periods.

+ This product may be inappropriate for people who are eligible for Medicaid coverage.

** Not generally qualified benefits under Section 125 Plans.

Group Critical Illness is only offered on an after tax-basis.

These are brief descriptions of the actual policies. All products may not be available in all states.

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

Employee Assistance Program (EAP)

Empathia

LifeMatters by Empathia – Assistance with Life, Work, and Wellbeing

When you or your family members need useful ideas, helpful resources, or reliable professional care, LifeMatters is just a phone call away. Free, confidential LifeMatters services include:

Telephone and face-to-face counseling

- 24/7 LifeMatters EAP help line services
- Eight (8) sessions in-person counseling
- Verified referrals to treatment covered by insurance
- Referrals to community programs and resources
- Six (6) sessions telephonic tobacco cessation program
- Five (5) annual hours for on-site trauma response services. Additional on-site trauma response services are available at a rate of \$250/hour and travel rate of \$125/hour



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

WorkLife Services

- Financial consultation and referral resources
- Legal consultation and referral resources
- **Online and assisted searches for:**
 - Child and elder care resources and guidance
 - Summer camps
 - Schools and colleges
 - Adoption services
 - Pet services
 - Volunteer opportunities
- Access to mylifematters.com
 - Interactive courses
 - Calculators
 - Self-assessments
 - Articles and videos
 - Scheduled and archived webinars covering topics in well-being, work/life and management

LifeMatters' user-friendly, confidential services are available to you and your eligible dependents 24 hours a day, every day of the year. Language assistance services in your preferred spoken and written languages are available at no cost.

Services provided directly by LifeMatters are free. If you are referred to outside resources, you will be advised about your costs, if any. For more information, call LifeMatters at 800.367.7474 or visit mylifematters.com – password **coe**.

Important Notices

Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 805.385.7473 for more information.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, 805.385.7473.

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

You do not need prior authorization from the plan 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, 805.385.7473.

Networks/Claims/Appeals

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

Notice of Extended Coverage to Children Covered as Students

"Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who, as a condition of coverage, is enrolled in an institution of higher education. Please review the following information with respect to your dependent child's rights in the event student status is lost.

Michelle's Law requires the Plan to allow extended eligibility in some cases for a covered child who would lose eligibility for Plan coverage due to loss of full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- *Dependent child means a child of a plan participant who is eligible under the terms of the Plan based on their student status and enrollment at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.*
- *Medically necessary leave of absence means a leave of absence or any other change in enrollment:*
 - Of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury;
 - Which is medically necessary; and,
 - Which causes the dependent child to lose student status under the terms of the Plan.

The dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

Important Notices (continued)

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- *One year after the first day of the leave of absence; or*
- *The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student).*

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

COBRA Continuation Coverage

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation

coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

Important Notices (continued)

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

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

NOTICE AND ELECTION PROCEDURES

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

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

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

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

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

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

Important Notices (continued)

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

IF YOU HAVE QUESTIONS

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans subject to ERISA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa (Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

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

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

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

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

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

Important Notices (continued)

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

For information about Special Enrollment Rights, please contact:

Charlie Lam
Human Resources Technician
805.385.7473
Charlie.lam@oxnard.org

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

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

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

- **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- **CalPERS has determined that the prescription drug coverage offered by 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 to December 7th.

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

Important Notices (continued)

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current City of Oxnard coverage will not be affected. If you keep this coverage and elect Medicare, the City of Oxnard coverage will coordinate with Part D coverage.

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

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

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

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

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

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

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

REMEMBER

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

Date: September 2019

Name of Entity / Sender: City of Oxnard

Contact: Charlie Lam

Address: 300 West 3rd Street
Oxnard, CA 93030

Phone: 805.385.7473

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

City of Oxnard Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Charlie Lam, 805.385.7473.

Important Notices (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through Covered California is anticipated to begin November 1, 2019 and end on the following January 31. Open Enrollment for most other states will begin on November 1 and close on December 15 of each year.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not “Affordable,” or does not provide “Minimum Value.” If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.78% (for 2020) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

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

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

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

PART B: EXCHANGE APPLICATION INFORMATION

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

3. Employer name City of Oxnard	4. Employer Identification Number (EIN) 95-6000756	
5. Employer address 300 West Third Street	6. Employer phone number 805.385.7473	
7. City Oxnard	8. State CA	9. ZIP code 93012
10. Who can we contact about employee health coverage at this job? Charlie Lam, Human Resource Technician.		
11. Phone number (if different from above)	12. Email address Charlie.lam@oxnard.org	

Important Notices (continued)

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

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

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility.

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

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

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

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

FLORIDA – Medicaid
Website: <http://flmedicaidprecovery.com/hipp/>
Phone: 877.357.3268

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

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: <http://www.in.gov/fssa/hip/>
Phone: 877.438.4479
All other Medicaid
Website: <http://www.indianamedicaid.com>
Phone: 800.403.0864

IOWA – Medicaid
Website:
<http://dhs.iowa.gov/hawki>
Phone: 800.257.8563

KANSAS – Medicaid
Website: <http://www.kdheks.gov/hcf/>
Phone: 785.296.3512

KENTUCKY – Medicaid
Website: <http://chfs.ky.gov/agencies/dms>
Phone: 800.635.2570

LOUISIANA – Medicaid
Website: <http://dhh.louisiana.gov/index.cfm/subhome/1/n/331>
Phone: 888.695.2447

MAINE – Medicaid
Website: <http://www.maine.gov/dhhs/ofi/public-assistance/index.html>
Phone: 800.442.6003
TTY: Maine relay 711

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

MINNESOTA – Medicaid
Website: <http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp> | Phone: 800.657.3739

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

Important Notices (continued)

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 800.694.3084

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
Phone: 855.632.7633
Lincoln: 402.473.7000
Omaha: 402.595.1178

NEVADA – Medicaid

Medicaid Website: <https://dhcfp.nv.gov/>
Medicaid Phone: 800.992.0900

NEW HAMPSHIRE – Medicaid

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

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
<http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Medicaid Phone: 609.631.2392
CHIP Website: <http://www.njfamilycare.org/index.html>
CHIP Phone: 800.701.0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800.541.2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/>
Phone: 919.855.4100

NORTH DAKOTA – Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
Phone: 844.854.4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 888.365.3742

OREGON – Medicaid

Websites: <http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
Phone: 800.699.9075

PENNSYLVANIA – Medicaid

Website:
<http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancemepremiumpaymenthippprogram/index.htm>
Phone: 800.692.7462

RHODE ISLAND – Medicaid

Website: <http://www.eohhs.ri.gov/>
Phone: 855.697.4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov>
Phone: 888.549.0820

SOUTH DAKOTA - Medicaid

Website: <http://dss.sd.gov>
Phone: 888.828.0059

TEXAS – Medicaid

Website: <http://gethipptexas.com/>
Phone: 800.440.0493

UTAH – Medicaid and CHIP

Medicaid Website: <https://medicaid.utah.gov/>
CHIP Website: <http://health.utah.gov/chip>
Phone: 877.543.7669

VERMONT– Medicaid

Website: <http://www.greenmountaincare.org/>
Phone: 800.250.8427

VIRGINIA – Medicaid and CHIP

Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 800.432.5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 855.242.8282

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>
Phone: 800.562.3022, ext. 15473

WEST VIRGINIA – Medicaid

Website: <http://mywvhipp.com/>
Toll-free phone: 855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP

Website:
<https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>
Phone: 800.362.3002

WYOMING – Medicaid

Website: <https://wyequalitycare.acs-inc.com/>
Phone: 307.777.7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565



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