2024 BENEFITS

CITY OF PITTSBURG

BENEFITS IN FOCUS

CONTENTS

MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

GETTING STARTED

2024 BENEFITS

January 1, 2024
through
December 31, 2024

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, City of Pittsburg supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, retirement benefits, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

You are eligible if you are an employee working 20 or more hours per week.

Employees with variable hours and seasonal schedules may be considered eligible for benefits. Refer to "Determining Eligibility" later in this guide for details.

Eligible dependents

- Legally married spouse.
- Registered Domestic Partner (RDP), where applicable by state law, is eligible for coverage if you have completed a Domestic Partner Affidavit.
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the benefit booklets for each benefit.

Who is not eligible

Members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Employees who work less than 20 hours per week, temporary employees not on City of Pittsburg's payroll, contract employees, or employees residing outside the United States.

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first of the month following date of hire. You must enroll within 30 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 30 days of the date the event occurs.
3. All proper documentation is required to cover dependents(marriage certificates, birth certificates, etc.).

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 30 days after the event.

Dependent Verification

Making changes to dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You will be required to provide proof of one or more of the following within XX days of their eligibility:

- Marriage Certification or License
- Domestic Partners Affidavit
- Birth Certificate
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)

If you do not supply the proper documentation to make changes to dependents within the 30-day period, you will not be able to add the dependent(s) until the next open enrollment period.

CITY OF PITTSBURG ACTIVE EMPLOYEE CONTRIBUTIONS

Medical Plan Rates for 2024 PMG and POA			
INSURANCE PROGRAMS			
PROGRAM	**EMPLOYEE**	**DUAL**	**FAMILY**
KAISER (Eff. 1/1/24)			
Total	926.75	1787.50	2501.93
City Share	926.75	1787.50	2501.93
Employee Share	0.00	0.00	0.00
Per Payday	0.00	0.00	0.00
ANTHEM EPO (Eff. 1/1/24)	**Closed to new enrollments effective 7/1/19**		
Total	1245.34	2534.57	3589.54
City Share	1032.95	2036.52	2864.47
Employee Share	212.39	498.05	725.07
Per Payday	106.20	249.02	362.54
ANTHEM PPO (Eff. 1/1/24)			
Total	944.08	1894.74	2650.00
City Share	932.53	1823.25	2551.29
Employee Share	11.55	71.49	98.71
Per Payday	5.78	35.75	49.36

For those employees having medical and/or dental insurance through a source other than their City employment, the City makes alternative reimbursement as follows:

MEDICAL		DENTAL
Single	$200.00/mo	$25.00/month
Dual	$300.00/mo	
Family	$500.00/mo	

To receive alternative payment(s) for medical and/or dental insurance coverage, employees must complete a Waiver of Insurance form and submit proof of insurance to the Human Resources Department.

ACTIVE EMPLOYEE CONTRIBUTIONS, CONTINUED

Medical Plan Rates for 2024

Misc. A, MPC, Teamsters, Senior Executive Team, IBEW, Management Group and Elected Officials

INSURANCE PROGRAMS

PROGRAM	EMPLOYEE	DUAL	FAMILY
KAISER (Eff. 1/1/24)			
Total	926.75	1787.50	2501.93
City Share	926.75	1787.50	2501.93
Employee Share	0.00	0.00	0.00
Per Payday	0.00	0.00	0.00
ANTHEM EPO (Eff. 1/1/24)	**Closed to new enrollments effective 7/1/19**		
Total	1245.34	2534.57	3589.54
City Share	926.75	1787.50	2501.93
Employee Share	318.59	747.07	1087.61
Per Payday	159.30	373.54	543.81
ANTHEM PPO (Eff. 1/1/24)			
Total	944.08	1894.74	2650.00
City Share	926.75	1787.50	2501.93
Employee Share	17.33	107.24	148.07
Per Payday	8.67	53.62	74.04

For those employees having medical and/or dental insurance through a source other than their City employment, the City makes alternative reimbursement as follows:

MEDICAL		DENTAL
Single	$200.00/mo	$25.00/month
Dual	$300.00/mo	
Family	$500.00/mo	

To receive alternative payment(s) for medical and/or dental insurance coverage, employees must complete a Waiver of Insurance form and submit proof of insurance to the Human Resources Department.

Dental, Vision and EAP rates for 2024

Dental, Vision and EAP is 100% City paid

Active Employees	Dental (non AFSCME)	Dental (AFSCME)	EAP	VSP Vision
Single	50.00	52.80	4.10	14.10
Dual	92.50	97.80	4.10	14.10
Family	159.60	169.00	4.10	14.10

MEDICAL

OUR PLANS

KAISER PERMANENTE

ANTHEM BLUE CROSS EPO

ANTHEM BLUE CROSS PPO

All About Medical Plans

We offer three medical plans through Anthem Blue Cross and Kaiser Permanente. Review the network provider information and out-of-pocket costs such as deductible, coinsurance and prescription drugs so you can choose the best fit for your health concerns and budget.

Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

Consider a PPO (Preferred Provider Organization) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers

Consider an HMO (Health Maintenance Organization) or an EPO (Exclusive Provider Organization) if:

- You want lower, predictable out-of-pocket costs
- You like having one doctor to manage your care
- You are happy with the selection of network providers
- You don't see any doctors that are out-of-network
- You have convenient access to Kaiser facilities

ANTHEM MEDICAL PLANS – EPO & PPO

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

	Anthem EPO (Closed to new enrollment)	Anthem PPO	
	In-Network	In-Network	Out-Of-Network
Annual Deductible	$0 per individual $0 family limit	$250 per individual $500 family limit	$250 per individual (combined with in-network) $500 family limit (combined with in-network)
Annual Out-of-Pocket Max	$2,000 per individual $3,000 family limit	$2,000 per individual	Not applicable
Lifetime Max	Unlimited	Unlimited	Unlimited
Office Visit			
Primary Provider	$15 copay then plan pays 100%	$20 copay then plan pays 100%	plan pays 60% after deductible
Specialist	$15 copay then plan pays 100%	$20 copay then plan pays 100%	plan pays 60% after deductible
Preventive Services	Plan pays 100%	plan pays 100%	Not covered
Chiropractic Care	$15 copay then plan pays 100% (combined acupuncture limit: up to 20 visits per year)	plan pays 80% after deductible (up to 40 visits per year)	plan pays 60% after deductible (in-network limitations apply)
Lab and X-ray	plan pays 100%	plan pays 80% after deductible	plan pays 60% after deductible
Inpatient Hospitalization	plan pays 100%	Plan pays 80% after deductible	plan pays 50% after deductible
Outpatient Surgery	plan pays 100%	plan pays 80% after deductible	plan pays 50% after deductible
Urgent Care	$15 copay then plan pays 100%	plan pays 80% after deductible	plan pays 50% after deductible
Emergency Room	$50 copay then plan pays 100% (copay waived if admitted)	plan pays 80% after deductible	plan pays 80% after deductible

ANTHEM PRESCRIPTION DRUG PLANS - EPO & PPO

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure.

Below is the prescription drug plans that are offered with our Anthem Blue Cross plans.

	Anthem EPO (Closed to new enrollment)	Anthem Rx PPO	
	In-Network	In-Network	Out-Of-Network
Annual Out-of-Pocket Limit	Prescriptions subject to medical out-of-pocket maximums	Prescriptions subject to medical out-of-pocket maximums	Prescriptions subject to medical out-of-pocket maximums
Pharmacy			
Generic	$10 copay then plan pays 100%	$10 copay then plan pays 100%	$10 copay then plan pays 100%
Preferred Brand	$20 copay then plan pays 100%	$20 copay then plan pays 100%	$20 copay then plan pays 100%
Non-preferred Brand	Not covered	Not covered	Not covered
Supply Limit	100 days	100 days	100 days
Mail Order			
Generic	$10 copay then plan pays 100%	$10 copay then plan pays 100%	$10 copay then plan pays 100%
Preferred Brand	$20 copay then plan pays 100%	$20 copay then plan pays 100%	$20 copay then plan pays 100%
Non-preferred Brand	Not covered	Not covered	Not covered
Supply Limit	100 days	100 days	100 days

KAISER MEDICAL PLAN – HMO

Here is an overview of our HMO medical plan offered through Kaiser Permanente.

	Kaiser HMO
	In-Network
Annual Deductible	$0 per individual $0 family limit
Annual Out-of-Pocket Max	$1,500 per individual $3,000 family limit
Lifetime Max	Unlimited
Office Visit	
Primary Provider	$15 copay then plan pays 100%
Specialist	$15 copay then plan pays 100%
Preventive Services	plan pays 100%
Chiropractic Care	$15 copay then plan pays 100% (combined acupuncture limit: up to 20 visits per year)
Lab and X-ray	plan pays 100%
Inpatient Hospitalization	plan pays 100%
Outpatient Surgery	$15 copay then plan pays 100%
Urgent Care	$15 copay then plan pays 100%
Ambulance Services	plan pays 100%
Emergency Room	$35 copay then plan pays 100% (copay waived if admitted)

Kaiser Prescription Drug Plans – HMO

Below is the prescription drug plans that are offered with our Kaiser Permanente plan.

	Kaiser Rx HMO
	In-Network
Pharmacy	
Generic	$10 copay then plan pays 100%
Preferred Brand	$20 copay then plan pays 100%
Non-preferred Brand	$20 copay then plan pays 100%
Supply Limit	100 days
Mail Order	
Generic	$10 copay then plan pays 100%
Preferred Brand	$20 copay then plan pays 100%
Non-preferred Brand	$20 copay then plan pays 100%
Supply Limit	100 days

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

FSA TAX SAVINGS EXAMPLE

$60,000 Annual Pay, with $1,500 FSA Contribution

$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings

$120,000 Annual Pay, with $2,750 FSA Contribution

$660 24% Federal income tax	**$210** 7.65% FICA tax	**$870** Annual FSA tax savings

Your tax savings may vary depending on tax filing status and other variables

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through American Fidelity.

How the FSA works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to $3,050, the 2024 annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.
- Expenses must be incurred between 01/01/2024 and 12/31/2024 and claims must be submitted for reimbursement no later than 03/15/2024. If you don't spend all the money in your account before the end of the year, you forfeit the leftover balance.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- You must re-enroll in this program each year.

TAX-FREE DEPENDENT CARE FSA

Eligible expenses may include daycare centers, in-home childcare, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can set aside up to $5,000 per household for eligible dependent care expenses for the year.

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up to $5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by American Fidelity.

Here's how the Dependent care FSA works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to $2,500 each year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Estimate carefully! You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

TURNING 65? UNDERSTAND YOUR MEDICARE OPTIONS

Alliant
MEDICARE SOLUTIONS

Alliant Medicare Solutions is a no cost service available to you, your family members, and friends nearing age 65.

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

Whether you retire or continue to work, choosing the right healthcare option is an important decision when you reach age 65

Most people become eligible for Medicare at age 65. When that happens, you'll probably have some time-sensitive decisions to make, based on your individual situation.

Introducing Alliant Medicare Solutions

Medicare can be complicated. Figuring out the rules—not to mention how Medicare works with or compares to your employer-provided medical coverage—can be a headache. That's why we are offering Alliant Medicare Solutions. The licensed insurance agents at AMS can help you understand Medicare, what is and isn't covered, and how to choose the best coverage for your situation.

How does it work?

1. Call Alliant Medicare Solutions at **(877) 888-0165** to speak to a licensed insurance agent. Have your current medical coverage information available when you call.
2. Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work the best for you.
3. If Medicare is the best option, Alliant Medicare Solutions helps you enroll immediately or emails policy materials for you to review and enroll at a later date.

Find Out More

Your Guide to Medicare

Medicare 101 Video

Social Security Planning Video

EVERY LIFE INCLUDES TRANSITIONS

GET THE ANSWERS YOU NEED

Transitions offers individualized education and advice about your options related to:

- Medicare coordination
- Social Security planning
- Retirement readiness
- COBRA alternatives
- Caregiving

A benefit for all ages and stages of life

It's said that the only constant in life is change. Whether that means getting ready for retirement, becoming one of the 31.8 million American workers who's also a caregiver for a loved one, or trying to figure out how to continue your benefits coverage through COBRA after a job transition, you'll probably have questions when you face life's many changes. That's where Transitions comes in.

No-cost resources and advice for your situation

If you or your family members need to know more about Medicare, Social Security, retirement, or COBRA, Transitions can provide resources such as videos, webinars, and interactive how-tos. You can even get individualized support for your specific scenario. Some examples:

- Your relative is ill and needs help finding a long-term care facility immediately.
- You're retiring in the next few years and you're not sure what to do about Medicare and Social Security.
- You're prescribed a medication that isn't covered under your insurance and is too expensive to pay for on your own.
- Your spouse—whose insurance covered the whole family—has been laid off, and COBRA is so expensive.

Transitions is available to you, your spouse, and your family members. There are no age requirements to use this benefit.

Getting started is easy

To access your Transitions benefits, sign up at transitionsrbg.com or download the Transitions RBG app. Once you've provided some information, Transitions will verify your benefit and you'll have access to all Transitions benefits. And just so you know, Transitions doesn't store any of your personally identifiable information.

You can also email info@transitionsrbg.com or call (800) 936-1405 if you have questions.

CalPERS RETIREMENT

The City of Pittsburg pays into the California Public Employees' Retirement System (CalPERS). All full-time and regular part-time employees must make retirement contributions through bi-weekly payroll deductions. Rates of contributions are based on the employees' represented unit. Retirement benefit amounts are calculated using the employee's service credit, benefit factor and final compensation.

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

- Tier One (Classic Members hired before July 10, 2011): Classic Formula 2% @ age 55; final compensation will be based on any 12 highest consecutive months.
- Tier Two (Classic Members hired after July 10, 2011): Classic Formula 2% @ age 60; final compensation will be based on the average of 3 consecutive years prior to retirement date.
- PEPRA – (Non-Reciprocal employees' hires after January 13, 2013): New Formula 2% @ age 62; final compensation will be based on the average of 3 consecutive years prior to retirement date.

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

- Tier One (Classic Members hired before October 30, 2011): Classic Formula 3% @ age 50; final compensation will be based on any 12 highest consecutive months.
- Tier Two (Classic Members hired after October 30, 2011): New Formula 3% @ age 55; final compensation will be based on any 12 highest consecutive months.
- PEPRA (Non-Reciprocal employees' hires after January 1, 2013): New Formula 2.7% @ age 57; final compensation will be based on the average of 3 consecutive years prior to retirement date.

Retirement provisions for all employees include the following:

- An employee becomes vested in retirement system after 5 years of service.
- Employees in Tier One are eligible to retire as early as age 50. Employees in Tier Two are eligible to retire at age 52. Early retirement is subject to proration of retirement rates stated above.
- The employee pays the required employee contribution portion. This amount is deducted from employee payroll deduction. The funds paid by the employee go into an account and earn interest. If you separate from employment for reasons other than retirement, you are entitled to withdraw these funds or if vested, leave them in the account and defer retirement.
- Employees who have service credit with other CalPERS agencies or have service in a reciprocal member agency will receive retirement benefits for those years based on the respective agency's retirement formula and final compensation.
- Retirees may receive a cost-of-living adjustment up to 3% per year for Tier 1 and 2% per year for Tier 2 and PEPRA.
- Employees interested in learning more about their retirement may contact CalPERS directly at 888.225.7377 or visit the CalPERS website at www.calpers.ca.gov alternatively, employees may also contact Human Resources at 252-4878.

CalPERS RETIREMENT, CONTINUED

MISSIONSQUARE RETIREMENT HEALTH SAVINGS (RHS) PLAN

New regular employees are provided a Retirement Health Savings (RHS) plan, to which the City and Employee shall both contribute $75 per month. Participation in the plan is required by the employee. The VantageCare Retirement Health Savings (RHS) Program is designed to help employees and their loved ones meet a critical expense — retiree health care — through a tax-advantaged savings vehicle. The RHS Program is sponsored by the City and administered by MissionSquare. All contributions to the account are set aside exclusively for qualifying medical expenses. For additional information on any of these benefits sponsored by MissionSquare, please visit website at https://www.missionsq.org or call MissionSquare at 1-800-669-7400.

DEFERRED COMPENSATION

Full-time and permanent part-time employees can elect to participate in a voluntary 457 (b) retirement plan. The City provides a “matching” contribution to a 457 deferred compensation plan for participating regular employees. The current matching amount is $150 per month for non-sworn regular full-time employees and $100 per month for sworn full-time employees. 457 plans are non-qualified, tax-advantaged, deferred compensation retirement plans offered by state, local government and some nonprofit employers. Eligible participants are able to make salary deferral contributions, depositing pre-tax money that is allowed to compound without being taxed until it is withdrawn. For information on Empower Retirement, please visit https://www.empower-retirement.com/ or call 1-855-756-4738.

DENTAL

OUR PLANS

DELTA DENTAL PPO

DID YOU KNOW?

Keeping your teeth and gums healthy isn't the only reason you should practice preventive dental care. With good dental hygiene, you can greatly reduce your risk of getting cavities, gingivitis, periodontitis, and other dental problems.

You can also reduce your risk of secondary problems caused by poor oral health such as diabetes, heart disease, osteoporosis, respiratory disease and even cancer.

We offer one dental plan through Delta Dental.

Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

DELTA DENTAL PPO

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

	Delta Dental PPO Non-AFSCME Employees		Delta Dental PPO AFSCME Employees	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Calendar Year Deductible	$50 per individual	$50 per individual (combined with in-network)	$50 per individual	$50 per individual (combined with in-network)
Annual Plan Maximum	$2,000 per individual	$2,000 per individual (combined with in-network)	$2,500 per individual	$2,500 per individual (combined with in-network)
Waiting Period	None	None	None	None
Diagnostic and Preventive	plan pays 70%-100% after deductible	plan pays 70%-100% after deductible	plan pays 70%-100% after deductible	plan pays 70%-100% after deductible
Basic Services				
Fillings	plan pays 70%-100% after deductible	plan pays 70%-100% after deductible	plan pays 70%-100% after deductible	plan pays 70%-100% after deductible
Root Canals	plan pays 70%-100% after deductible	plan pays 70%-100% after deductible	plan pays 70%-100% after deductible	plan pays 70%-100% after deductible
Periodontics	plan pays 70%-100% after deductible	plan pays 70%-100% after deductible	plan pays 70%-100% after deductible	plan pays 70%-100% after deductible
Major Services	plan pays 70%-100% after deductible	plan pays 70%-100% after deductible	plan pays 70%-100% after deductible	plan pays 70%-100% after deductible
Orthodontic Services				
Orthodontia	Plan pays 70% after deductible	Plan pays 70% after deductible	Plan pays 70% after deductible	Plan pays 70% after deductible
Lifetime Maximum	$2,500	$2,500 (combined with in-network)	$2,500	$2,500 (combined with in-network)
Dependent Children Only	Covered	Covered	Covered	Covered

DELTA DENTAL RESOURCES

ANDROID APP ON Google play

Available on the App Store

ONLINE SERVICES -

WWW.DELTADENTALINS.COM

- Printable ID cards
- Secure login for benefits and eligibility lookup
- Claims status available to enrollees & dentists
- Dentist directory with maps & driving directions
- Extensive dental health section
- Enrollee section in Spanish
- SmileKids – an interactive site for children
- Fee Finder
- Explanation of Benefits – use it!
- Articles and Quizzes on Oral Health Dental Wire Newsletter

Delta dental mobile app

USING THE APP WITHOUT LOGGING IN

Anyone can use Delta Dental Mobile without logging in to access our Find a Dentist and Toothbrush Timer tools, conveniently located on the home screen. You also have the option to save your ID card to the home screen for easy access without logging in.

Logging in to view benefits

Delta Dental subscribers can log in using the username and password they use to log in to our website. If you haven't registered, there is a link on the home screen to register for an account. If you've forgotten your username or password, you can also retrieve these via Delta Dental Mobile

Securely access your benefits

You must enter your username and password each time you access the secure portion of the app. No personal health information is ever stored on your device. For more details on security, our Privacy Policy can be viewed via a link on the Login page of the app.

Important tips

Pre-Treatment estimate - Make sure you always get one so you know how much you will be paying BEFORE you get to your appointment!

- If you are having extensive dental work done
- Ensuring that a procedure is covered
- To see if you will exceed your maximum when getting orthodontics or implant coverage
- If you need to plan your payment in advance
- If you would like an advance breakdown of the charges and coverage

DELTA DENTAL MEMBER DISCOUNTS

As a Delta Dental Member, you have access several discount programs!

While your oral health remains the top priority, Delta Dental also care about the bigger picture — your overall well-being[1]. That's why dental member now have access to preferred pricing on hearing aid and LASIK services through Amplifon Hearing Health Care and QualSight[2].

Access to sizeable savings	62% average savings off retail hearing aid pricing,[3] backed by a best price guarantee[4]	40-50% off the national average price of Traditional LASIK[5]
Convenient locations	Broad nationwide network of providers	1,000+ LASIK locations[6]
Quality care and products	Access to the nation's leading brands featuring the latest hearing aid technology	Experienced LASIK surgeons who have collectively performed 6.5+ million procedures6
Customized support	Amplifon acts as your personal concierge at every step, from appointment scheduling and hearing aid selection to coordinating follow-up care.	A QualSight care manager will walk you through the program, coordinate care and help select the right physician and procedure.
For more information	Amplifon's hearing aid discounts, visit www.amplifonusa.com/deltadentalins or call 1-888-779-1429. Patient Care Advocate will help you find a hearing care provider near you.	QualSight's LASIK discounts, visit www.qualsight.com/-delta-dental or call 1-855-248-2020. A care manager will explain the program and answer any questions.

1 Delta Dental of California, Delta Dental Insurance Company, Delta Dental of Pennsylvania, Delta Dental of New York, Inc. and our affiliated enterprise companies.

2 The Vision Corrective Services and hearing health care services are not insured benefits. Delta Dental makes the Vision Corrective Services program available to enrollees to provide access to the preferred pricing for LASIK surgery. Delta Dental makes the hearing health care services program available to enrollees to provide access to the preferred pricing for hearing aids and other hearing health services.

3 Amplifon Hearing Health Care utilization database, January-December 2018. Discounts or savings may vary by manufacturer and technology level of the hearing aid device.

4 Amplifon offers a price match on most hearing devices; some exclusions apply. Not available where prohibited by law. Visit www.amplifonusa.com/deltadentalins or call 1-888-779-1429 for more details.

5 Refractive Quarterly Update, Market Scope LLC, November 2018. Discounts or savings may vary by provider.

6 QualSight provider file, February 2019

VISION

OUR PLANS

VSP VISION

Click to play video

We offer on vision plan through VSP.

Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

VSP VISION

Routine vision exams can not only correct vision, but also detect more serious health conditions. When you enroll in the Vision Service Plan Vision plan, you are also provided with coverage through Vision Service Plan.

	PRISM Vision Service Plan Vision	
	In-Network	**Out-Of-Network**
Examination Benefit	Plan pays 100%	Plan pays 100% (reimbursed up to $50)
Frequency	1 x every 12 months from last date of service	In-network limitations apply
Materials	Plan pays 100%	Plan pays 100% (see schedule below)
Eyeglass Lenses Single Vision Lens	plan pays 100% of basic lens	Reimbursed up to $50
Bifocal Lens	plan pays 100% of basic lens	Reimbursed up to $75
Trifocal Lens	plan pays 100% of basic lens	Reimbursed up to $100
Frequency	1 x every 12 months from last date of service	In-network limitations apply
Frames Benefit	Reimbursed up to $150, balance plus a plan pays 20% discount from the remaining	Reimbursed up to $70
Frequency	1 x every 24 months from last date of service	In-network limitations apply
Contacts (Elective) Benefit	Fitting & evaluation exam: Reimbursed up to $130	Reimbursed up to $105 (in-network limitations apply)
Frequency	1 x every 12 months from last date of service	In-network limitations apply

VSP RESOURCES

VSP Vision Riders and Discounts

- A vision exam helps detect the signs of health conditions like high blood pressure, diabetes, and high cholesterol—along with other eye and health issues.

Better provider choice with VSP

- You can choose your provider from 71,000 access points, including the largest national network of independent doctors and nearly 4,500 participating retail chain locations. For convenience, most VSP participating doctors also offer early morning, evening and weekend appointments, and 24-hour access to emergency care.
- If you prefer to use a non-network provider, this option is also available under our plan however, the benefit allowances are lower.

Exclusive member discounts & Extra savings on glasses & sunglasses

- Extra $20 to spend on featured frame brands. Go to www.vsp.com/specialoffers for details.
- 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.
- Eyeconic®, an easy-to-use, in-network, online eyewear platform is also available to all members. Eyeconic® offers free shipping and returns, virtual try-on tool, free frame adjustment or contact lens consultation and all-inclusive pricing on glasses and lenses. For more information on Eyeconic®, visit eyeconic.com

Laser vision correction

- Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor

Hearing aid discount

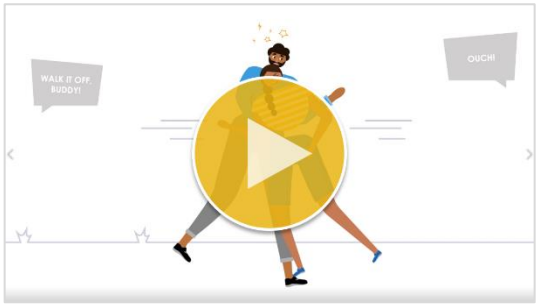
VSP® Vision Care members can save up to $2,400 on a pair of digital hearing aids. Dependents and even extended family members are eligible for exclusive savings, too.

TruHearing also provides members with:

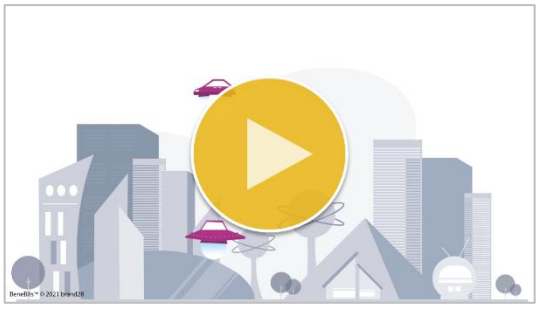
- 3 provider visits for fitting, adjustments, and cleanings
- A 45-day money back guarantee
- 3-year manufacturer's warranty for repairs and one-time loss and damage
- 48 free batteries per hearing aid.

ENGAGE

Click to play video



Urgent Care vs ER



Virtual Healthcare

Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	**$0**
Online visit 	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	**$**
Office visit 	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room 	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	**$$$$$**

ALTERNATIVE FACILITIES

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

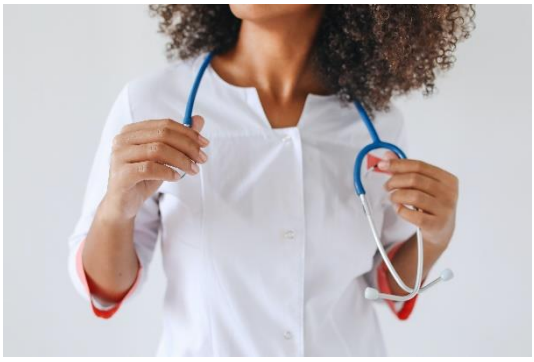
Need	Alternative	Features	Savings
Surgery 	Ambulatory Surgery Center (ASC)	▪ Specializes in same-day surgeries ▪ Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more ▪ Held to same safety standards as hospitals	Up to 50% over hospital stay*
Physical therapy 	Free-standing physical therapy center	▪ Important part of the recovery process after an injury or surgery	40 to 60% over a hospital setting*
Sleep study 	Home testing	▪ Diagnoses sleep apnea and other conditions ▪ Cost is often covered by insurance if considered medically necessary	Approx. $4,500*
Infusion therapy 	Home or outpatient infusion therapy	▪ For drugs that must be delivered by intravenous injections, or epidurals ▪ Delivered by licensed infusion therapy provider ▪ Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% over hospital stay* **in-network*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on your plan's website; or call member services for assistance.

Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings. Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

PREVENTIVE CARE SCREENING BENEFITS



TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit **cdc.gov/prevention** for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide short and long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children.

COMPANY-PROVIDED LIFE AND AD&D INSURANCE

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by Lincoln and premiums are paid in full by the City of Pittsburg.

A NOTE ABOUT TAXES

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

Lincoln Financial Group PRISM – Life and AD&D		
Basic Life and AD&D Benefits	**Basic Life Amount**	**Basic AD&D Amount**
Class 1 City Manager	$350,000	$350,000
Class 2 Senior Executives and Management Group	1.5 times of covered annual earnings up to $250,000	1.5 times of covered annual earnings up to $250,000
Class 3 Police Captains	$100,000	$100,000
Class 4 All other full-time Members	$75,000	$75,000
Class 5 Council Members	$75,000	$75,000
Class 6 Part-time Members (minimum of 20 hours)	$25,000	$25,000

VOLUNTARY LIFE AND AD&D INSURANCE

Employee Benefit:

Guaranteed Life and AD&D Insurance Coverage Amount

Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to$100,000 without providing evidence of insurability.

Annual Limited Enrollment: If you are a continuing employee, you can increase your coverage amount by $10,000 or$20,000 without providing evidence of insurability . If you submitted evidence of insurability in the past and were declined for medical reasons, you may be required to submit evidence of insurability.

Evidence of Insurability (EOI)

If you elect Voluntary Life coverage above guaranteed issue (noted on this page), or if you are a late entrant (enrolling more than 31 days after the date you become eligible), you must complete and submit EOI. This can be completed through Lincoln.

Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Lincoln and available for your spouse and/or child(ren).

Employee Benefit	
Newly hired employee guaranteed coverage amount	$100,000
Continuing employee guaranteed coverage annual increase amount	Choice of $10,000 or $20,000
Maximum coverage amount	Five times your annual salary ($500,000 maximum in increments of $10,000)
Minimum coverage amount	$10,000

Spouse Benefit	
Newly hired employee guaranteed coverage amount	$25,000
Continuing employee guaranteed coverage annual increase amount	Choice of $5,000 or $10,000
Maximum coverage amount	50% of the employee coverage amount ($250,000 maximum in increments of $5,000)
Minimum coverage amount	$5,000

Dependent Child(ren) Benefit	
Six months to age 26 guaranteed coverage amount	$1,000 to $10,000
Age one day to six months guaranteed coverage amount	$500

In the event of a serious or fatal accident

Voluntary AD&D Insurance allows you to purchase accidental death and dismemberment coverage that pays your beneficiary if you have a fatal accident. If you experience a serious injury such as a loss of a limb, speech, sight or hearing, the plan pays a benefit to you. Coverage is provided by Lincoln and is available for your spouse and/or child(ren).

VOLUNTARY LIFE AND AD&D INSURANCE (cont'd)

If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense. You can increase this amount by up to $20,000 during the next limited open enrollment period.

Maximum Life and AD&D Insurance Coverage Amount

You can choose a coverage amount up to 5 times your annual salary ($500,000 maximum) with evidence of insurability. See the Evidence of Insurability page for details.

Your coverage amount will reduce by 35% when you reach age 65 and an additional 15% of the original amount when you reach age 70.

Spouse Coverage - You can secure term Life and AD&D Insurance for your spouse if you select coverage for yourself.

Guaranteed Life and AD&D Insurance Coverage Amount

Initial Open Enrollment: When you are first offered this coverage, you can choose a coverage amount up to 50% of your coverage amount ($25,000 maximum) for your spouse / domestic partner without providing evidence of insurability.

Annual Limited Enrollment: If you are a continuing employee, you can increase the coverage amount for your spouse / domestic partner by $5,000 or $10,000 without providing evidence of insurability. If you submitted evidence of insurability in the past and were declined for medical reasons, you may be required to submit evidence of insurability.

If you decline this coverage now and wish to enroll later, evidence of insurability may be required and may be at your own expense. You can increase this amount by up to $10,000 during the next limited open enrollment period.

Maximum Life and AD&D Insurance Coverage Amount

You can choose a coverage amount up to 50% of your coverage amount ($250,000 maximum) for your spouse / domestic partner with evidence of insurability.

Coverage will term at age 70 or employee retirement, whichever occurs first.

Dependent Children Coverage: You can secure term Life and AD&D Insurance for your dependent children when you choose coverage for yourself.
Guaranteed Life and AD&D Insurance Coverage Options: Increments of $1,000 up to $10,000

Evidence of Insurability

If you select a coverage amount above a certain limit, you will need to submit an Evidence of Insurability form with additional information about your health in order for the insurance company to approve this higher amount of coverage.

LONG-TERM DISABILITY INSURANCE (LTD)

Long-Term Disability (LTD) coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security.

If you qualify, long-term disability benefits begin after short-term disability benefits end. Coverage is provided by Lincoln Financial Group.

Lincoln Financial Group - LTD	
Monthly Benefit Amount	Plan pays 60% of the first $15,000 of your predictability earnings
Maximum Monthly Benefit	$9,000
Benefits Begin After:	
• Accident	180 days of disability
• Sickness	180 days of disability
Maximum Payment Period*	Social Security Normal Retirement Age

*The age at which the disability begins may affect the duration of the benefits.

State Disability Program

ABOUT THE STATE DISABILITY INSURANCE PROGRAM

California State Disability Insurance (SDI) is a partial wage-replacement insurance plan for eligible California workers. The SDI program is state-mandated and funded through employee payroll deductions. Workers covered by SDI have two benefits available to them: Disability Insurance (DI) and Paid Family Leave (PFL). More than 18 million California workers are covered by the SDI program.

To request general program information or data about State Disability Insurance, complete the State Disability Insurance Request for Information Form (DE 2541E) and return it to the EDD using the appropriate email address listed on the form.

Note: Inquiries about individual claims using this form will not be answered.

DISABILITY INSURANCE

DI was established in 1946 to provide short-term benefits to eligible California workers who have a loss of wages when they are unable to work due to a non-work-related illness, injury, or pregnancy.

To learn more about DI, visit Disability Insurance or the State Disability Insurance FAQs.

PAID FAMILY LEAVE

PFL provides benefits to individuals who need to take time off work to care for a seriously ill child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or registered domestic partner, or to bond with a new child entering the family through birth, adoption, or foster care placement.

To learn more about PFL, visit Paid Family Leave, the Paid Family Leave Fact Sheet (PDF), or the State Disability Insurance FAQs.

SDI ONLINE

SDI Online provides customers with convenient and secure online claim filing and management options that are simple to use and available 24 hours a day, 7 days a week. SDI Online reduces claim processing time, provides immediate confirmation of forms submitted, decreases costs in paper and postage, and includes security safeguards to detect and manage fraud and abuse.

To file a DI or PFL claim in SDI Online, you must first complete a one-time registration to establish a Benefit Programs Online (BPO) account. Visit Benefit Programs Online and select Register to start creating an account now.

After you have registered for and logged in to BPO, select SDI Online which will direct you to the SDI Online Registration Options. Once your registration is complete, log in to BPO and select SDI Online to be directed to your home page to file your claim.

https://www.edd.ca.gov/Disability/About_the_State_Disability_Insurance_(SDI)_Program.htm

PORAC

Insurance & Benefits Trust / Committee of PORAC

GROUP SHORT TERM/LONG TERM DISABILITY PLAN

The Disability program is for Police Officers, Sergeants, and Lieutenants only. It is designed to protect one of your most important assets; your ability to earn a paycheck. If you become disabled due to an injury or illness and can't work, this program is designed to provide you and your family with a continuing monthly income up to a maximum of $10,000 per month.

The Disability program provides this protection around the clock — 24/7. This program far exceeds other plans offered to Peace Officers and provides unparalleled financial security. Listed below are the three Safety and two Non-Safety Disability plans offered:
Silver Plan beginning at $18.50 per month is totally self-funded and offers coverage for a period not to exceed 24 months.

Gold Plan beginning at $29.70 per month provides both Short Term Disability (STD) and Long-Term Disability (LTD) coverage protecting up to 66 2/3% of your monthly salary. Under the STD Plan, benefits are self-funded by the Insurance and Benefits Trust of PORAC (IBT) during the initial 12 months of a claim, after which your coverage seamlessly transitions to the fully insured LTD Plan which is underwritten and administered by the Standard Insurance Company.

Platinum Plan beginning at $34.00 per month provides both STD and LTD coverage protecting up to 70% of your monthly salary. Under the STD Plan, benefits are self-funded by the IBT during the initial 12 months of a claim, after which your coverage seamlessly transitions to the fully insured LTD Plan which is underwritten and administered by the Standard Insurance Company.

The Gold and Platinum Non-Safety plans are fully self-funded by the IBT and have a three-year Maximum Benefit Period

For more information, go to the following link: Group Short Term/Long Term Disability Plan

GROUP LIFE INSURANCE

As a peace officer you protect the public. The Life Insurance program provides you with the means to assist in financially safeguarding and protecting your loved ones. Protect them against you unexpectedly dying by protecting yourself. The IBT has had a relationship with Myers Stevens & Toohey & Co. Inc (MST) since 1970 to administer these plans. Click here for more information: Group Life Insurance

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE EAP

Phone
800-834-3773

Website
www.claremonteap.com

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Claremont can help you handle a wide variety of personal issue such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 8 visits per issue
- Unlimited web access to helpful articles, resources, and self-assessment tools

COUNSELING BENEFITS

- Difficulty with relationship
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

FINANCIAL COACHING

- Money management
- Debt management
- Identity theft resolution
- Tax issues

LEGAL CONSULTATION

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

LINCOLN EMPLOYEECONNECT (EAP)

CONTACT EMPLOYEECONNECT

Phone

Toll-free (888) 628-4824, available 24 hours a day

Website

www.guidanceresources.com

Username: LFGSupport

Password: LFGSupport1

Help for you and your household members

EmployeeConnect offers professional, confidential services to help you and your loved ones improve your quality of life. Lincoln's *EmployeeConnect* is here 24/7 to connect or refer you to a professional who can help with marriage, family and relationship issues; problems in the workplace; stress, anxiety and sadness; grief, loss, or responses to traumatic events; concerns about your use of alcohol or drugs; and financial and legal issues.

You and your household members are entitled to 5 face-to-face sessions or unlimited telephonic or online consultations for problem-solving support per individual, per incident, per policy year. You also receive one free 30-minute in-personal legal consultation per legal issue (**25% off** subsequent meetings).

All services are confidential and in accordance with professional ethics and federal and state laws. Use of the EAP is strictly voluntary.

The EAP is offered to you in addition to the Anthem EAP Program.

Unlimited 24/7 Assistance

You and your family can access the following services anytime – online, on the mobile app, or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning and more
- Legal information and referrals for family law, estate planning, consumer and civil law
- Financial guidance on household budgeting and short- and long-term planning

Online Resources

EmployeeConnect offers a wide range of information and resources you can research and access on your own. Expert Advice and support tools are just a click away when you visit guidanceresources.com or download the *GuidanceNow* mobile app. You'll find:

- Article and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets, and more

TRAVEL ASSISTANCE (ADMINISTERED BY LFG)

CONTACT INFO

Phone
866.525.1955 (U.S.) or
603.328.1955 (Outside U.S.)

Website
www.mysearchlightportal.com
Code: LFGTravel123

Make travel less stressful

TravelConnect is a comprehensive program that can bring help, comfort, and reassurance if you face a medical emergency while traveling 100 or more miles from home (see your plan for details). Whether traveling for business or leisure, if you are enrolled in the life and/or AD&D plan, you and your loved ones can count on TravelConnect for responsive and caring support, 24 hours a day, 7 days a week.

TravelConnect can assist you with:

- Emergency pet boarding and/or return
- Return of traveling companion
- ID recovery assistance
- Vehicle return
- Emergency travel arrangements
- Lost or stolen travel documents
- Language translation services
- Medical and dental referrals
- Corrective lens and medical device replacement
- Medication and vaccine delivery
- Evacuation coordination for an emergency security or political event, or natural disaster*
- Destination information

**On Call International must coordinate and provide all arrangements for eligible services to be covered. Coverage is subject to contract language that contains specific terms, conditions and limitations*

ONLINE WILL PREPARATION (ADMINISTERED BY LFG)

Having a will allows you to designate who will receive your property and assets when you're gone. Without one, your state determines how your estate is distributed. Online will preparation services are available with LifeKeys services, which is included with your life insurance policy from Lincoln Financial Group. EstateGuidance will preparation is a quick and easy way to create and execute a will.

Online will preparation allows you to document your final wishes, such as

- Beneficiaries to inherit property
- Naming a guardian to care for minor children

Online will preparation is straightforward

- Create, save and print a legally binding will that you can change at any time.
- Detailed instructions and definitions guide you through the process.
- All personal legal forms and documents are stored on a secure server and are only accessible via password.
- You can make unlimited revisions at no cost.

Getting started is easy

1. Go to https://www.estateguidance.com/ and click "Get Started" at the top to begin.

2. Create your account and enter "Lifekeys" in the Promotional Code field to receive the discounted products.

3. Click "Get Started" under Last Will and Testament.

4. Answer the preliminary questions. You can add a Living Will or Final Arrangements for an additional cost. Click "Get Started" to proceed.

5. Enter your personal information and click "Next" to move through all 8 sections (Personal, Family, Estate, Gifts, Remainder, Minors, Legal Rep and Other).

6. Congratulations, you've completed your will! You can download the document to your computer or have it emailed to you for free or request a printed copy for $14.99.

Be sure to sign and date your Last Will and Testament in the presence of qualified witnesses and a notary public, as detailed at ***EstateGuidance.com***

Visit the website today or call 855.891.3684 for help.*

*No legal advice is provided

SAVE ON COMMUTE EXPENSES

Transportation Savings Account—up to $560 per month tax-free

Do you have out-of-pocket commuting expenses for public transportation, van pooling, or for worksite parking? If so, you can save on taxes by enrolling in our transportation savings account, administered by Cubic Transportation Systems Inc.

The account lets you set aside money—before it's taxed—through payroll deduction. You may enroll in or stop this program at any time. Money in the account can be used in future months or plan years.
Set aside up to $280 per month for work-related parking expenses and up to $280 per month for work-related commute expenses.

SCHOLARSHARE 529 PLAN

Learn how to save for college with ScholarShare 529.

What is a 529?

A 529 plan is an account that allows you to invest specifically for future education expenses. Similar to IRAs and 401(k)/403(b) plans designed to help save for retirement, 529 plans are aimed at helping families save for college. The accounts are administered at the state level, and are managed by a financial services company that handles all the paperwork and oversees the investments.

Learn more about how ScholarShare 529 is a better way to save for college:

TAX-FREE
Contributions grow tax-free, which can mean more money for college. Withdrawals are tax-free when the money is used for qualified higher education expenses.

FLEXIBLE
Funds can be used at eligible schools nationwide. So whether the beneficiary wants to be a rocket scientist, welder or chef, they're covered.

ACCESSIBLE
Anyone who is a U.S. citizen or resident alien and at least 18 years old who would like to contribute on behalf of a beneficiary (the person for whom you are contributing money, including a minor child, a spouse or yourself) can establish a 529 account.

VALUABLE
529s can be used to cover a range of expenses, including mandatory fees, books, supplies, and equipment required for enrollment or attendance, along with certain room and board costs.

ScholarShare529

800.544.5248 | ScholarShare529.com

SCHOLARSHARE 529 PLAN, CONTINUED

Common Myths about 529 Plans.

Here are some common myths and misunderstandings about 529 plans and the truth behind them.

529 savings plans are only for families interested in public colleges or universities.

FALSE. Funds can be used from your 529 savings plan to send your grandkids, loved ones, or even yourself to any accredited public or private U.S. college or university—or two-year technical or vocational institution—as well as qualifying international institutions.

I must open a 529 account in the state where my beneficiary will attend college.

FALSE. You can invest your money in almost any state's 529 plan, the majority of which have no residency requirements. Before investing in a particular plan, you should consider whether the state in which you or your designated beneficiary reside or have taxable income offers any specific benefits. Some states allow you to deduct contributions from your taxable state income, giving you a financial incentive to invest in your home state plan. See the plan description for any plan you are considering for more details.

All 529 plans are the same.

FALSE. While all 529 accounts offer flexible investment options, they can be different depending on where they are maintained and by whom. Some ways they can vary include contribution limits defined by the state administrator, fees to open and/or maintain an account, investment options offered, the financial services company that manages the plan and whether a state tax deduction or credit is available to residents participating in the plan. There may also be special programs or benefits defined by the particular plan.

My beneficiary gains control of my money when I open a 529 plan for them.

FALSE. The account owner is always in charge. This means you control the funds in any 529 account you open. The beneficiary cannot withdraw money, change investment options or do anything else without your consent.

FAQS ABOUT 529 COLLEGE SAVINGS PLANS

Q: Can more than one person contribute to the account?
Anyone can contribute to an account as long as the maximum account balance does not exceed the per-beneficiary threshold set by the sponsoring state. The account owner has sole control over the assets and decides when to withdraw them.

Q: Can I change the beneficiary?
You can change your beneficiary at any time or transfer a portion of your investment to a different beneficiary. To maintain the tax benefits, the new beneficiary must be an eligible member of the previous beneficiary's family under the IRS definition, such as a sibling, an aunt, a stepchild, a first cousin or a spouse.

Q: What if my child or loved one decides not to attend college?
You have three choices:
1. Keep the funds in the account, and the investments will be available in future years if the beneficiary changes his or her mind about school.
2. Change the beneficiary to an eligible family member. Consult your tax advisor about whether this may create a taxable gift.
3. Make a nonqualified withdrawal. You can withdraw your principal contributions without a penalty, but any earnings will be subject to applicable state and federal taxes, plus a 10% federal penalty and potentially 2.5% California tax on earnings.

Q: What if my child or loved one gets a full or partial scholarship?
If your child receives a scholarship that covers the cost of qualified higher education expenses, you can withdraw funds up to the scholarship amount without any penalty. However, you'll have to pay federal and sometimes state income taxes on the earnings portion of the withdrawal.

Q: If I open an account in my state, then move to another state, what will happen to the account?
If you move to another state, you can still keep your money invested in your account, and you can continue contributing to it. Remember, before investing in any 529 plan, consider whether the state in which you or your designated beneficiary reside has a 529 plan that offers state income tax or other benefits to residents.

IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Contact information for our benefit carriers and vendors
- Holiday Schedules, Paid Time Off, and Payroll Calendar
- A Benefits Glossary to help you understand important insurance terms.
- A summary of the health plan notices you are entitled to receive annually, and where to find them

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify CLIENT NAME if your domestic partner is your tax dependent.

PLAN CONTACTS

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website	Policy No.
Medical	Anthem (teamsters)	(800) 888-8288	teamsters.org	EPO – 280436 PPO - 280558
Medical	Kaiser (teamsters)	(800) 464-4000	teamsters.org	HMO - 7038
RX	Optum RX	(800) 797-9791	optumrx.com	N/A
Dental	Delta Dental	(800) 765-6003	deltadentalins.com	20499
Vision	VSP (PRISM)	(800) 877-7195	vsp.com	0555
Life and AD&D,LTD	Lincoln Financial Group (PRISM)	(800) 423-2765	lfg.com	800017
FSA, Supplemental Plans	American Fidelity	(800) 662-1113	americanfidelity.com	N/A
EAP	Claremont	(800) 834-3773	claremonteap.com	001429
Transit	P&A Group	(716) 852-2611	www.padmin.com	TBD
Teamsters	Teamsters Assistance Program	(510) 562-3600	tap-program.org/	N/A
PORAC	Insurance & Benefits Trust (IBT)	(800) 655-6397	www.porac.org	N/A
Retirement	CalPERS	(888) 225-7377	calpers.ca.gov	N/A
Retirement Health Savings	MissionSquare	(800) 669-7400	www.missionsq.org	N/A
Deferred Compensation	Empower Retirement	(855) 756-4738	empower-retirement.com	N/A
College Savings Plan	ScholarShare 529	(800) 544-5248	www.scholarshare529.com	N/A
Human Resources	City of Pittsburg	(925) 252-4878	www.pittsburgca.gov/	N/A

TIME AWAY FROM WORK

2024 Holiday Schedule

Below is the Holiday Schedule for 2024. Please Note: Holidays falling on Saturday are observed the preceding Friday; holidays falling on Sunday are observed the following Monday; Holidays falling during the week are observed on the actual day.

New Year's Day	Monday, January 1
MLK Day	Monday, January 15
Lincoln's Birthday	Monday, February 12
Washington's Birthday	Monday, February 19
Cesar Chavez Day	Monday, April 1
Memorial Day	Monday, May 27
Independence Day	Thursday, July 4
Labor Day	Monday, September 2
Columbus Day	Monday, October 14
Veterans' Day	Monday, November 11
Thanksgiving Holidays	Thursday, November 28 and Friday, November 29
Christmas Day	Wednesday, December 25
Winter Closure	Tuesday, December 24 – Tuesday, December 31
New Year's Day 2025	Monday, January 1

City of Pittsburg Sick Leave Accrual Policy

Below is an outline of the City of Pittsburg's Sick Leave Accrual Policy. This applies to Sr. Executive Team, Management Group, Management, Professional, Confidential & MISC "A" (AFSCME), Teamsters, IBEN, Police Management Group and Police Officers' Association.

Sick Leave Accrual:	Accrue 3.69 hours per pay period
Incentive:	4 hours credited to vacation leave w/no usage of SL during any payroll year quarter.
Personal Necessity Leave:	May use up to 32 hours/year
Bereavement Leave: Immediate family is defined as spouse, domestic partner, children, parents, grandparents, grand-children, brothers, sisters, stepchildren, stepparents, half-brothers, half-sisters, fathers-in-law, and mothers-in-law.	5 days (3 days paid leave, 2 days unpaid) for death of immediate family member: to be taken within six months of death.

2024 Payroll Calendar

	PP No.	Start Date		End Date	Transmission Date (Direct Dep.)	Actual Payday (Check Date)	
1st Quarter	1	12/24/23	-	01/06/24	01/10/24	01/11/24	Holiday: December 25th and January 1st Winter Closure December 22nd thru December 29th
	2	01/07/24	-	01/20/24	01/24/24	01/25/24	Holiday: January 15th
	3	01/21/24	-	02/03/24	02/07/24	02/08/24	
	4	02/04/24	-	02/17/24	02/21/24	02/22/24	Holiday: February 12th **All timesheets must be approved by 10:00 a.m. on Friday, February 16th - NO EXCEPTIONS** (Holiday February 19th)
	5	02/18/24	-	03/02/24	03/06/24	03/07/24	Holiday: February 19th
	6	03/03/24	-	03/16/24	03/20/24	03/21/24	
2nd Quarter	7	03/17/24	-	03/30/24	04/03/24	04/04/24	**All timesheets must be approved by 10:00 a.m. on Friday, March 29th- NO EXCEPTIONS (Holiday April 1st)**
	8	03/31/24	-	04/13/24	04/17/24	04/18/24	Holiday: April 1st
	9	04/14/24	-	04/27/24	05/01/24	05/02/24	
	10	04/28/24	-	05/11/24	05/15/24	05/16/24	
	11	05/12/24	-	05/25/24	05/29/24	05/30/24	**All timesheets must be approved by 10:00 a.m. on Friday, May 24th - NO EXCEPTIONS** (Holiday May 27th) "Free Check" - No Extra Deductions
	12	05/26/24	-	06/08/24	06/12/24	06/13/24	Holiday: May 27th
	13	06/09/24	-	06/22/24	06/26/24	06/27/24	
3rd Quarter	14	06/23/24	-	07/06/24	07/10/24	07/11/24	Holiday: July 4th
	15	07/07/24	-	07/20/24	07/24/24	07/25/24	
	16	07/21/24	-	08/03/24	08/07/24	08/08/24	
	17	08/04/24	-	08/17/24	08/21/24	08/22/24	
	18	08/18/24	-	08/31/24	09/04/24	09/05/24	**All timesheets must be approved by 10:00 a.m. on Friday, Aug. 30th - NO EXCEPTIONS** (Holiday September 2nd)
	19	09/01/24	-	09/14/24	09/18/24	09/19/24	Holiday: September 2nd Vacation Buy Back (Sept. elections) - Subject to contract negotiations
4th Quarter	20	09/15/24	-	09/28/24	10/02/24	10/03/24	
	21	09/29/24	-	10/12/24	10/16/24	10/17/24	**All timesheets must be approved by 10:00 a.m. on Friday, Oct. 11th - NO EXCEPTIONS (Holiday October 14th)**
	22	10/13/24	-	10/26/24	10/30/24	10/31/24	Holiday: October 14th "Free Check" = No Extra Deductions
	23	10/27/24	-	11/09/24	11/13/24	11/14/24	**All timesheets must be approved by 10:00 a.m. on Friday, Nov. 8th - NO EXCEPTIONS (Holiday November 11th)**
	24	11/10/24	-	11/23/24	11/26/24	11/27/24	Holiday: November 11th **All timesheets must be approved by 10:00 a.m. on Friday, Nov. 22nd - NO EXCEPTIONS (Holiday November 28th)**
	25	11/24/24	-	12/07/24	12/11/24	12/12/24	Holidays: November 28th and 29th Vacation Buy Back (Dec. elections) - Subject to contract negotiations
	26	12/08/24	-	12/21/24	12/24/24	12/26/24	**All timesheets must be approved by 10:00 a.m. on Friday, December 20th - NO EXCEPTIONS** (Holiday December 25th) **Winter Closure December 24th thru December 31st**

Please note: sick leave incentive for bonus vacation follows pay period quarters and not calendar quarters.

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located here.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

DEADLINE FOR FILING LAWSUIT UNDER ERISA AFTER EXHAUSTION OF ALL CLAIMS PROCEDURES

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan specific statute of limitations.

Medicare Part D Notice

Important Notice from The City of Pittsburg About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Pittsburg has determined that the prescription drug coverage offered by the health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your The City of Pittsburg coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **Important Note for Retiree Plans:** Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

Since the existing prescription drug coverage under The City of Pittsburg is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your The City of Pittsburg prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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

You should also know that if you drop or lose your current coverage with The City of Pittsburg and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information [or call The City of Pittsburg at 925-252-4878 .NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The City of Pittsburg changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 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 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:	01/01/2024
Name of Entity/Sender:	The City of Pittsburg
Contact-Position/Office:	Human Resources
Address:	65 Civic Avenue, Pittsburg, CA 94565
Phone Number:	925-252-4878

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at 925-252-4878 .

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in The City of Pittsburg health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in The City of Pittsburg health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in The City of Pittsburg health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for The City of Pittsburg describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting your health plan.

Notice of Choice of Providers

Kaiser Permanente generally allows 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the health plan.

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

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 | Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov | KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 | Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 617-886-8102
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp | Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
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: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.12% in 2023 of your modified adjusted household income.