2018

Employee Benefits Guide

Sunnyvale

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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 Notices and Documents* section for more details.

Welcome to the City of Sunnyvale

Welcome! At the City of Sunnyvale, we value your contribution to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

The City of Sunnyvale takes pride in offering a benefits program that provides comprehensive coverage for the needs of our employees and their families. The City provides eligible employees with valuable benefits, including:

- Health insurance
- Dental insurance
- Vision insurance
- Life and Disability insurance
- Flexible Spending Accounts (FSAs)
- CalPERS Retirement and deferred compensation plans

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan documents will govern in the event of any conflict between this description and the plan documents.

A list of plan contacts is included at the back of this guide.

The benefits in this summary are effective:

January 1, 2018 - December 31, 2018

Open Enrollment

This booklet will give you information about the benefits which are available to you. Please read the information carefully. To help you make important decisions about your benefits, the Human Resources staff is available to answer any questions you may have.

OPEN ENROLLMENT

Beginning on **September 11, 2017 through October 6, 2017**, all plan participants will be eligible to participate in the annual open enrollment period. During Open Enrollment, you have the right to elect or change plans and add or drop dependents from coverage.

Your new plan benefits will be **effective January 1, 2018** and will run through December 31, 2018. The deadline to submit all health enrollment forms to the Department of Human Resources is 5pm on Friday, October 6, 2017.

Please call the Employee Benefits Division at (408) 730-7490 if you have any questions.

HELPFUL HINTS

Read through this guide to familiarize yourself with what decisions you have to make. Think about your current benefit plans. Are they still working for you? Have you experienced any changes or do you anticipate any changes that might make a different plan more suitable?

Gather additional information. Use the websites and phone numbers in the *Plan Contacts* section to see which doctors and other healthcare providers you can use under the different plan choices. If you have dependents on your plan that live out of state, check on provisions for coverage of members away from home.

Enrollment Forms & Links

BENEFITS CALCULATION SHEETS

Use these worksheets to estimate your bi-weekly paycheck costs for benefits.

Calculation Sheet	Weblink
2018 COA	http://bit.ly/2018calcsheets 1) Click on link above 2) Choose worksheet 3) Click download
2018 Council	
2018 Management	
2018 PSOA	
2018 SEA & Confidential	
2018 SEIU Standard	
2018 SEIU Grandfathered	

ENROLLMENT FORMS

All forms needed to make changes for open enrollment are available below.

Forms	Weblink
Health Enrollment & Change Form Use this form for changes to medical, dental and/or vision.	http://bit.ly/2018forms 1) Click on link above 2) Choose desired form(s) 3) Click download
Flexible Spending Account Form Use this form to enroll in the health and/or dependent care flexible spending account program for the 2018 plan year.	
Life Insurance Enrollment Form Use this form to apply for supplemental life & AD&D coverage.	
Life Insurance: Evidence of Insurability Form Attach this form to the *Life Insurance Enrollment form* if you did not elect supplemental life, AD&D insurance within 30 days of hire. (Election beyond 30 days is subject to insurer approval).	
Other Forms - Other forms like Beneficiary Designation and 457 deferral change forms are available via this link.	

CASH-IN-LIEU FORMS

The cash in lieu incentive is available to COA, Council, Unrepresented Management and SMA employees who waive enrollment in a medical plan. PSOA cash in lieu is closed to new participation. Please contact the Department of Human Resources to obtain a form.

SUMMARIES OF BENEFITS AND COVERAGE

Copies of each medical plan's Summaries of Benefits and Coverage can be found here: http://bit.ly/2018sbc.

2018 Monthly Premiums

Medical – CalPERS Bay Area Region*

**The Bay Area Region includes Alameda, Amador, Contra Costa, Marin, Napa, Nevada, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Sutter, and Yuba counties. For other CalPERS region rates contact the Department of Human Resources at (408) 730-7490. To calculate your bi-weekly employee cost, please refer to the calculation sheets for your employee group.*

Medical plan premiums for 2018 are as follows:

Medical Plan	Employee Only	Employee + 1	Employee + Family
Anthem Select HMO	$856.41	$1,712.82	$2,226.67
Anthem Traditional HMO	$925.47	$1,850.94	$2,406.22
Blue Shield Access+ HMO	$889.02	$1,778.04	$2,311.45
HealthNet SmartCare HMO	$863.48	$1,726.96	$2,245.05
Kaiser CA HMO	$779.86	$1,559.72	$2,027.64
United Healthcare HMO	$1,371.84	$2,743.68	$3,566.78
Western Health Advantage	$792.56	$1,585.12	$2,060.66
PERS Choice PPO	$800.27	$1,600.54	$2,080.70
PERS Select PPO	$717.50	$1,435.00	$1,865.50
PERS Care PPO	$882.45	$1,764.90	$2,294.37
PORAC PPO	$734.00	$1,540.00	$1,970.00

Dental plan premiums for 2018 are as follows:

Dental Plan	Employee only	Employee + 1	Employee + Family
Delta Preferred PPO - Core	$41.62	$78.49	$130.26
Delta Preferred PPO - Buy-up	$58.87	$109.21	$173.86
Difference†	*$17.25*	*$30.72*	*$43.60*
Delta Care DHMO	$21.98	$39.55	$58.51

† Buy-up plan increases coverage, see Dental section. Employee pays the difference between Core and Buy-up coverage. Cafeteria contributions are not eligible to be applied to Buy-up costs.

2018 Monthly Premiums

Vision plan premiums for 2018 are as follows:

Vision Plan	Employee only	Employee + 1	Employee + Family
Vision Service Plan - Core	$7.60	$11.80	$17.60
Vision Service Plan - Buy-up	$9.60	$15.00	$22.40
Difference†	*$2.00*	*$3.20*	*$4.80*

† Buy-up plan increases coverage, see Vision section. Employee pays the difference between Core and Buy-up coverage. Cafeteria contributions are not eligible to be applied to Buy-up costs.

Life and Accidental Death & Dismemberment (AD&D) plan premiums for 2018 are as follows:

Premiums are for each $1,000 of coverage. For specific coverage levels and amounts, please refer to the *Life Insurance* section of this guide.

Life and AD&D Plan (Voya)	Life	AD&D
Basic Coverage (City-paid)	$0.099	$0.017
Supplemental Coverage	$0.178	$0.018

Employee Assistance Program

Premium is $5.44 per employee per month.

2018 City Contributions

The City contribution (including the cafeteria benefit), is negotiated through collective bargaining agreements. You are a key partner in the City's continuing effort to manage health care costs. Now more than ever, managing costs is essential.

Effective January 1, 2018, the monthly City contributions are as follows:

Unit	Coverage Tier	Medical Contribution	Cafeteria Contribution	Total City Contribution
Management	EE-only	$835.66	$536.18	$1,371.84
	EE+1	$835.66	$1,908.02	$2,743.68
	Family	$835.66	$2,731.12	$3,566.78
SEA / Confidential		$835.66	$899.98	$1,735.64
PSOA		$467.46	$47.54	$515.00
COA		$472.98	$342.02	$815.00
SEIU—Standard†		$459.64	$676.19	$1,135.83

† Grandfathered SEIU employees have a different cafeteria contribution. For more information, please contact the Employee Benefits Division at (408) 730-7490.

2018 Benefit Highlights

NEW WESTERN HEALTH ADVANTAGE HMO PLAN

Western Health Advantage HMO, a new plan partner for 2018, will provide coverage in the counties of Colusa, El Dorado, Marin, Napa, Placer, Sacramento, Solano, Sonoma, and Yolo.

RATE CHANGES FOR 2018

Medical

The CalPERS medical plan rates all experienced changes for 2018. Within the Bay Area Region, rates for the PERS Select (-2.5%), Choice (-3.6%) and Care (-5.3%) PPO plans all decreased. Rates for the HMO plans were mixed, with the following plans receiving an increase: UnitedHealthcare (29%), Health Net SmartCare (17.7%), Anthem HMO Select (9.3%) and Kaiser (6.3%). The remaining HMO plans saw a decrease: Blue Shield Access+ (-13.2%), and Anthem HMO Traditional (-6.5%).

Dental

The Delta Dental PPO and Buy-up plan rates decreased by 5.2%, while the Deltacare USA DHMO plan received a 3% increase.

Vision

The VSP Core and Buy-up plan rates are not changing and are guaranteed through 12/31/2020.

Life Insurance

In July 2017, the City received a 10% decrease to our Basic and Supplemental Life insurance rates. These rates are guaranteed through 6/30/2020.

PPO PLAN BENEFIT CHANGES

CalPERS introduced plan benefit changes for the PERS Select, PERS Choice, and PERSCare PPO plans, including:

- Expanding the use of Ambulatory Surgery Centers to include 12 new outpatient medical procedures, including sigmoidoscopies, tonsillectomies, and kidney stone treatments. A full list of the procedures will be listed in each health plan's Evidence of Coverage.
- Adding a site of care program to guide members who need certain prescription drug infusions to lower-cost sites than hospitals (e.g., doctor's office, ambulatory infusion center, or home infusion).
- A mobile application called Quick Care to help members quickly identify nearby clinics and doctors' walk-in offices, avoiding the need to use more expensive emergency room care for their urgent care needs.

Who Can You Cover?

WHO IS ELIGIBLE?

You are eligible for the City of Sunnyvale benefits program if you are a regular full-time or part-time employee working at least 21 hours per week.

After your initial benefits enrollment, unless you experience a qualifying life event, you cannot make mid-year changes in your elections, or add or drop dependents until the next Open Enrollment period.

Please refer to the *When You Can Make Changes* section for mid-year qualifying life event triggers that may allow you to change plans, or dependents.

WHEN YOU ARE ELIGIBLE

You are eligible for the benefits program as outlined below.

Unit	Coverage	Effective Date
Management	LTD: All other coverage:	*Dept. Directors*: 1st of the month following date of hire *Other Management*: After 26 pay periods of service 1st of the month following date of hire
PSOA† and COA†	Dental: LTD: All other coverage:	After 13 pay periods of service *PSOA*: Date of hire *COA*: After 26 pay periods of service 1st of the month following date of hire
SEA/Confidential and SEIU	LTD: All other coverage:	After 26 pay periods of service 1st of the month following date of hire

† Dental for COA and both Dental and LTD for PSOA are provided through the Association. Please contact the Association directly for specific plan details.

Who Can You Cover?

This is a brief description of the eligibility requirements and is not intended to modify or supersede the requirements of the plan documents. The plan documents will govern in the event of any conflict between this description and the plan documents.

DEPENDENT ELIGIBILITY

Your dependents are eligible for coverage under your health and welfare benefits package so long as they meet the requirements specified for each plan. Eligible dependents include:

- Your current **spouse** or **state-registered domestic partner**. Definition of domestic partner pursuant to Family Code Section 297-297.5: *A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State.*
- Your **natural children**, **stepchildren**, **domestic partner's children**, **adoptive children** of which the employee is the legal guardian. In addition, such children must be under age 26.
- Your **disabled children age 26 or older**. Such disabled children must meet the same conditions as listed above and in addition are physically or mentally disabled on the date coverage would otherwise end because of age and continue to be disabled.
- A child for whom you are required to **provide benefits by a court order** and who satisfies the same conditions as listed above.

Dependent Eligibility Verification

All employees adding or removing dependents must submit documentation to verify their dependent's eligibility and/or Qualifying Life Event. The following chart is an easy guide to what documents must be submitted along with the Health Enrollment/Change form.

	Enrollment Form	Marriage Certificate	Birth Certificate	State of CA DP Registration
Employee only	•			
Employee & Spouse	•	•		
Employee & Domestic Partner (DP)	•			•
Employee & Child(ren)	•		•	
Employee, Spouse/DP & Child(ren)	•	•	•	•

For enrollment into any Medical Plan, a copy of all enrollees' Social Security Card is also required.

You are responsible for ensuring that the health enrollment information about you and your family members is accurate, and for reporting any changes in a timely manner. If you fail to maintain current and accurate health enrollment information, it may impact dependent eligibility for health care continuation under COBRA and will result in you incurring liability for the reimbursement of health premiums or health care services incurred during the entire ineligibility period.

In the *When You Can Make Changes* section, you will find a detailed list of Qualifying Life Events, which must be reported to the Department of Human Resources so we can make the appropriate change to your health coverage. All Qualifying Life Event changes must be made within 30 days (or 60 days for CalPERS medical plans) from the date of the event. Proper documentation is required, such as a copy of the marriage/domestic partnership certificate, birth/adoption certificate, or divorce/dissolution of domestic partnership decree.

For further clarification, please contact the Department of Human Resources at (408) 730-7490.

When You Can Make Changes

Other than during the annual Open Enrollment period, you may not change your coverage unless you experience a qualifying life event.

Qualifying life events include:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, dissolution of domestic partnership, or death of a spouse.
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child.
- Change in employment status, including the start or termination of employment by you, your spouse, or your dependent child.
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits.
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid.
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child or dependent foster child.
- An event that is a qualifying life event under the Health Insurance Portability and Accountability Act (HIPAA), including acquisition of a new dependent or spouse or loss of coverage under another health insurance policy or plan if the coverage is terminated because of:
    - Voluntary or involuntary termination of employment or reduction in hours of employment or death, divorce, or legal separation;
    - Termination of employer contributions toward the other coverage, OR if the other coverage was COBRA Continuation Coverage, exhaustion of the coverage.

IMPORTANT—TWO RULES APPLY WHEN MAKING MID-YEAR CHANGES:

- Any changes you make must be consistent with the change in status, AND
- You must make the changes within 30 days (60 days for CalPERS medical plans) of the date the event (marriage, birth, etc.) occurs.

Getting Care When You Need It Now

WHEN TO USE THE ER

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life threatening condition that requires immediate attention or treatment that is only available at a hospital.

WHEN TO USE URGENT CARE

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

PREVENTIVE OR DIAGNOSTIC?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms.

Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change.

Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.

Medical

It is the City's goal to provide you with affordable, quality health care benefits. Our medical benefits are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. The City offers a choice of medical plans through the CalPERS Medical Program.

HEALTH MAINTENANCE ORGANIZATION (HMO)

2018 Insurers: Anthem Blue Cross, Blue Shield, Health Net, Kaiser Permanente, Western Health Advantage and UnitedHealthcare

Under HMO plans, most services and medicines are covered with a small copayment. Most HMOs require you to select a Primary Care Physician (PCP) to coordinate your care and require advance approval for some services, such as treatment by a specialist. Care must generally be obtained from in-network providers, or you may be required to pay out of pocket for the cost of services (except in the event of emergency or urgent care services). Not all HMO plans are available in all California counties. To see if these plans are available in your zip code, visit the CalPERS website at www.calpers.ca.gov and use the zip code finder search engine.

PREFERRED PROVIDER ORGANIZATION (PPO)

2018 Insurers: Anthem Blue Cross (PERS Choice, PERS Select, PERSCare, PORAC)

PPO plans are designed to provide choice, flexibility and value. A PPO plan is a managed care organization of medical doctors, hospitals, and other health care providers who have contracted with your insurer to provide health care at reduced rates to you. Participants have a choice of using network providers or going directly to any other physician (non-network provider) without a referral. For most services, there is an annual deductible to meet before benefits apply. You are also responsible for a certain percentage of the charges (coinsurance), and the plan pays the balance up to the agreed upon amount. Non-network providers are typically covered at a lower benefit level requiring you to pay a higher percentage of the bill.

Medical

CALPERS SEARCH TOOLS

CalPERS Health Plan Search by Zip Code

To find CalPERS health plans available in your area, search by zip code at www.calpers.ca.gov

CalPERS Health Plan Chooser

CalPERS offers a comparison tool to compare all medical plans and also confirm whether your doctor is in-network for the plan.

Reminder: Forms must be returned to the Department of Human Resources by **5pm on** October 6, 2017 to ensure enrollment and for coverage to be effective January 1, 2018.

Why Would I Choose the PPO Plan?	Why Would I Not Choose the PPO Plan?
• You have a doctor you like and you would like to keep this doctor. • You want to see specialists and other providers without having to first get a referral and/or pre-approval. • You want the freedom to see providers who are not in the network. • You are confident that you can manage your own care. • You do not want a primary care doctor.	• You don't want the extra responsibility of managing your own care. • PPOs are not as closely regulated by the government as HMOs. • You do not want to pay the higher costs of a PPO. • You do not want to get bills from providers.

Medical

Medical Benefits	Anthem Blue Cross Traditional HMO Anthem Blue Cross Select HMO
Calendar Year Deductible	N/A
Maximum Calendar Year Co-pay (excl. pharmacy)	$1,500 individual / $3,000 family
Hospitalization *(including Mental Health and Substance Abuse)* Deductible Inpatient/Outpatient	 N/A No charge
Emergency Room Deductible Emergency Room Co-pay *(For inpatient or for observation as an outpatient)* Non Emergency Co-pay *(For inpatient or for observation as an outpatient)*	N/A $50 (waived if admitted) $50 (waived if admitted)
Physician Services *(including Mental Health and Substance Abuse)* Office Visit Copay Inpatient Outpatient	 $15 / visit No Charge $15
Diagnostic X-Ray / Lab	No charge
Prescription Rx: Retail *(up to a 30 day supply only)* Generic Rx / Brand Name / Non-formulary	 $5 / $20 / $50
Prescription Rx: Retail Maintenance Medications *(for medications taken for 60 days or more not to exceed 30 day supply)* Generic Rx / Brand Name / Non-formulary	 $10 / $40 / $100
Prescription Rx: Mail Order Pharmacy *(not to exceed 90 day supply for maintenance drugs)* Generic Rx / Brand Name / Non-formulary	 $10 / $40 / $100
Maximum co-payment/person per calendar year	$1,000
Durable Medical Equipment	No charge
Infertility Testing/Treatment	50% of covered charges
Occupational/Physical/Speech Therapy	No charge (inpatient) / $15 (outpatient)
Diabetes Services Glucose Monitoring Self-Management Training	 No charge $15
Acupuncture / Chiropractic *(Limited to a combined 20 visits per calendar year)*	$15 / visit

Medical

Medical Benefits	Blue Shield Access+ HMO
Calendar Year Deductible	N/A
Maximum Calendar Year Co-pay (excl. pharmacy)	$1,500 individual / $3,000 family
Hospitalization *(including Mental Health and Substance Abuse)* Deductible Inpatient/Outpatient	 N/A No charge
Emergency Room Deductible Emergency Room Co-pay *(For inpatient or for observation as an outpatient)* Non Emergency Co-pay *(For inpatient or for observation as an outpatient)*	N/A $50 (waived if admitted) $50 (waived if admitted)
Physician Services *(including Mental Health and Substance Abuse)* Office Visit Copay Inpatient Outpatient	 $15 / visit No Charge $15
Diagnostic X-Ray / Lab	No charge
Prescription Rx: Retail *(up to a 30 day supply only)* Generic Rx / Brand Name / Non-formulary	 $5 / $20 / $50
Prescription Rx: Retail Maintenance Medications *(for medications taken for 60 days or more not to exceed 30 day supply)* Generic Rx / Brand Name / Non-formulary	 $10 / $40 / $100
Prescription Rx: Mail Order Pharmacy *(not to exceed 90 day supply for maintenance drugs)* Generic Rx / Brand Name / Non-formulary	 $10 / $40 / $100
Maximum co-payment/person per calendar year	$1,000
Durable Medical Equipment	No charge
Infertility Testing/Treatment	50% of covered charges
Occupational/Physical/Speech Therapy	No charge (inpatient) / $15 (outpatient)
Diabetes Services Glucose Monitoring Self-Management Training	 No charge $15
Acupuncture / Chiropractic *(Limited to a combined 20 visits per calendar year)*	$15 / visit

Medical

Medical Benefits	Kaiser Permanente HMO
Calendar Year Deductible	N/A
Maximum Calendar Year Co-pay (excl. pharmacy)	$1,500 individual / $3,000 family
Hospitalization *(including Mental Health and Substance Abuse)* Deductible Inpatient/Outpatient	 N/A No charge / $15
Emergency Room Deductible Emergency Room Co-pay *(For inpatient or for observation as an outpatient)* Non Emergency Co-pay *(For inpatient or for observation as an outpatient)*	N/A $50 (waived if admitted) $50 (waived if admitted)
Physician Services *(including Mental Health and Substance Abuse)* Office Visit Copay Inpatient Outpatient	 $15 / visit No Charge $15
Diagnostic X-Ray / Lab	No charge
Prescription Rx: Retail *(up to a 30 day supply only)* Generic Rx / Brand Name	 $5 / $20
Prescription Rx: Retail Maintenance Medications *(for medications taken for 60 days or more not to exceed 30 day supply)* Generic Rx / Brand Name	 N/A
Prescription Rx: Mail Order Pharmacy *(not to exceed 90 day supply for maintenance drugs)* Generic Rx / Brand Name	 $10 / $40
Maximum co-payment/person per calendar year	N/A
Durable Medical Equipment	No charge
Infertility Testing/Treatment	50% of covered charges
Occupational/Physical/Speech Therapy	No charge (inpatient) / $15 (outpatient)
Diabetes Services Glucose Monitoring Self-Management Training	 No charge $15
Acupuncture / Chiropractic *(Limited to a combined 20 visits per calendar year)*	$15 / visit

Medical

Medical Benefits	HealthNet SmartCare HMO
Calendar Year Deductible	N/A
Maximum Calendar Year Co-pay (excl. pharmacy)	$1,500 individual / $3,000 family
Hospitalization *(including Mental Health and Substance Abuse)* Deductible Inpatient/Outpatient	 N/A No charge
Emergency Room Deductible Emergency Room Co-pay *(For inpatient or for observation as an outpatient)* Non Emergency Co-pay *(For inpatient or for observation as an outpatient)*	N/A $50 (waived if admitted) $50 (waived if admitted)
Physician Services *(including Mental Health and Substance Abuse)* Office Visit Copay Inpatient Outpatient	 $15 / visit No Charge $15
Diagnostic X-Ray / Lab	No charge
Prescription Rx: Retail *(up to a 30 day supply only)* Generic Rx / Brand Name / Non-formulary	 $5 / $20 / $50
Prescription Rx: Retail Maintenance Medications *(for medications taken for 60 days or more not to exceed 30 day supply)* Generic Rx / Brand Name / Non-formulary	 $10 / $40 / $100
Prescription Rx: Mail Order Pharmacy *(not to exceed 90 day supply for maintenance drugs)* Generic Rx / Brand Name / Non-formulary	 $10 / $40 / $100
Maximum co-payment/person per calendar year	$1,000
Durable Medical Equipment	No charge
Infertility Testing/Treatment	50% of covered charges
Occupational/Physical/Speech Therapy	No charge (inpatient) / $15 (outpatient)
Diabetes Services Glucose Monitoring Self-Management Training	 No charge $15
Acupuncture / Chiropractic *(Limited to a combined 20 visits per calendar year)*	$15 / visit

Medical

Medical Benefits	UnitedHealthcare HMO
Calendar Year Deductible	N/A
Maximum Calendar Year Co-pay (excl. pharmacy)	$1,500 individual / $3,000 family
Hospitalization *(including Mental Health and Substance Abuse)* Deductible Inpatient/Outpatient	 N/A No charge
Emergency Room Deductible Emergency Room Co-pay *(For inpatient or for observation as an outpatient)* Non Emergency Co-pay *(For inpatient or for observation as an outpatient)*	N/A $50 (waived if admitted) $50 (waived if admitted)
Physician Services *(including Mental Health and Substance Abuse)* Office Visit Copay Inpatient Outpatient	 $15 / visit No Charge $15
Diagnostic X-Ray / Lab	No charge
Prescription Rx: Retail *(up to a 30 day supply only)* Generic Rx / Brand Name / Non-formulary	 $5 / $20 / $50
Prescription Rx: Retail Maintenance Medications *(for medications taken for 60 days or more not to exceed 30 day supply)* Generic Rx / Brand Name / Non-formulary	 $10 / $40 / $100
Prescription Rx: Mail Order Pharmacy *(not to exceed 90 day supply for maintenance drugs)* Generic Rx / Brand Name / Non-formulary	 $10 / $40 / $100
Maximum co-payment/person per calendar year	$1,000
Durable Medical Equipment	No charge
Infertility Testing/Treatment	50% of covered charges
Occupational/Physical/Speech Therapy	No charge (inpatient) / $15 (outpatient)
Diabetes Services Glucose Monitoring Self-Management Training	 No charge $15
Acupuncture / Chiropractic *(Limited to a combined 20 visits per calendar year)*	$15 / visit

Medical

Medical Benefits	Western Health Advantage HMO
Calendar Year Deductible	N/A
Maximum Calendar Year Co-pay (excl. pharmacy)	$1,500 individual / $3,000 family
Hospitalization *(including Mental Health and Substance Abuse)* Deductible Inpatient/Outpatient	 N/A No charge
Emergency Room Deductible Emergency Room Co-pay *(For inpatient or for observation as an outpatient)* Non Emergency Co-pay *(For inpatient or for observation as an outpatient)*	N/A $50 (waived if admitted) $50 (waived if admitted)
Physician Services *(including Mental Health and Substance Abuse)* Office Visit Copay Inpatient Outpatient	 $15 / visit No Charge $15
Diagnostic X-Ray / Lab	No charge
Prescription Rx: Retail *(up to a 30 day supply only)* Generic Rx / Brand Name / Non-formulary	 $5 / $20 / $50
Prescription Rx: Retail Maintenance Medications *(for medications taken for 60 days or more not to exceed 30 day supply)* Generic Rx / Brand Name / Non-formulary	 $10 / $40 / $100
Prescription Rx: Mail Order Pharmacy *(not to exceed 90 day supply for maintenance drugs)* Generic Rx / Brand Name / Non-formulary	 $10 / $40 / $100
Maximum co-payment/person per calendar year	$1,000
Durable Medical Equipment	No charge
Infertility Testing/Treatment	50% of covered charges
Occupational/Physical/Speech Therapy	No charge (inpatient) / $15 (outpatient)
Diabetes Services Glucose Monitoring Self-Management Training	 No charge $15
Acupuncture / Chiropractic *(Limited to a combined 20 visits per calendar year)*	$15 / visit

Medical

Medical Benefits	PERS Choice PPO PERS Select PPO	
	In Network	Out of Network
Calendar Year Deductible	$500 indiv / $1,000 family	$500 indiv / $1,000 family
Maximum Calendar Year Co-pay *(excl. pharmacy)*	$3,000 indiv / $6,000 family	N/A
Hospitalization *(incl. Mental Health and Substance Abuse)* Deductible Inpatient/Outpatient	 N/A 20%-30%	 N/A 40%
Emergency Room Deductible Emergency Room Co-pay *(inpatient or observation as outpatient)* Non Emergency Co-pay *(inpatient or observation as outpatient)*	$50 20% 20%	$50 20% 40%
Physician Services *(incl. Mental Health & Substance Abuse)* Office Visit Copay Inpatient Outpatient/Urgent Care	 $20 / visit 20% $20	 40% 40% 40%
Diagnostic X-Ray / Lab	20%	40%
Prescription Rx: Retail *(up to a 30 day supply only)* Generic / Brand Name / Non-formulary	 $5 / $20 / $50	 $5 / $20 / $50
Prescription Rx: Retail Maintenance Medications / Mail Order Pharmacy *Retail: taken for 60 days or more not to exceed 30 day supply; Mail Order: not to exceed 90 days supply for maintenance drugs* Generic / Brand Name / Non-formulary	 $10 / $40 / $100	 $10 / $40 / $100
Maximum co-payment/person per calendar year	$1,000	$1,000
Durable Medical Equipment	20%	40%
Infertility Testing/Treatment	Not covered	Not covered
Occupational/Physical/Speech Therapy	No charge (inpatient) / 20% (outpatient)	No charge (inpatient) / 20%-40% (outpatient)
Diabetes Services Glucose Monitoring Self-Management Training	 Coverage varies $20	 Coverage varies $20
Acupuncture / Chiropractic *(Limited to combined 20 visits/calendar yr)*	$15 / visit	40%

Medical

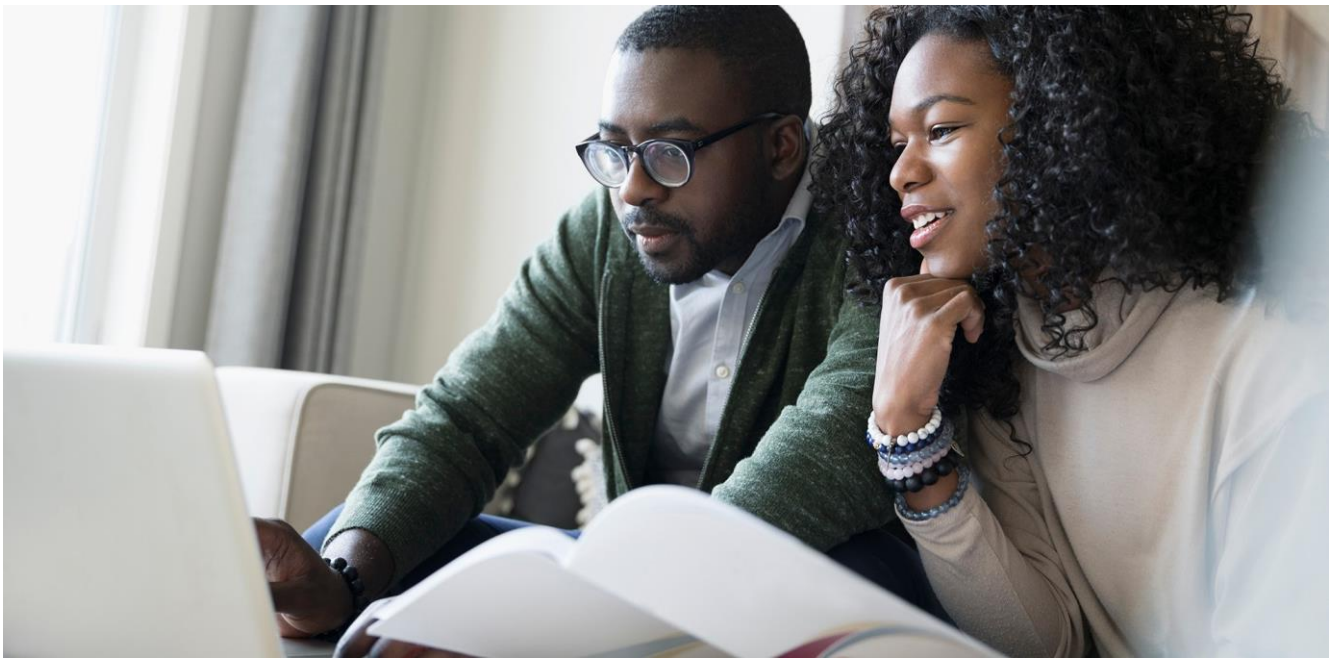
Medical Benefits	PERS Care PPO	
	In Network	Out of Network
Calendar Year Deductible	$500 indiv / $1,000 family	$500 indiv / $1,000 family
Maximum Calendar Year Co-pay *(excl. pharmacy)*	$2,000 indiv / $4,000 family	N/A
Hospitalization *(incl. Mental Health and Substance Abuse)* Deductible Inpatient/Outpatient	 $250 10%	 $250 40%
Emergency Room Deductible Emergency Room Co-pay *(inpatient or observation as outpatient)* Non Emergency Co-pay *(inpatient or observation as outpatient)*	$50 10% 10%	$50 10% 40%
Physician Services *(incl. Mental Health & Substance Abuse)* Office Visit Copay Inpatient Outpatient/Urgent Care	 $20 / visit 10% $20	 40% 40% 40%
Diagnostic X-Ray / Lab	10%	40%
Prescription Rx: Retail *(up to a 30 day supply only)* Generic / Brand Name / Non-formulary	 $5 / $20 / $50	 $5 / $20 / $50
Prescription Rx: Retail Maintenance Medications / Mail Order Pharmacy *Retail: taken for 60 days or more not to exceed 30 day supply; Mail Order: not to exceed 90 days supply for maintenance drugs* Generic / Brand Name / Non-formulary	 $10 / $40 / $100	 $10 / $40 / $100
Maximum co-payment/person per calendar year	$1,000	$1,000
Durable Medical Equipment	10%	40%
Infertility Testing/Treatment	Not covered	Not covered
Occupational/Physical/Speech Therapy	No charge (inpatient) / 10% (outpatient)	No charge (inpatient) / 10%-40% (outpatient)
Diabetes Services Glucose Monitoring Self-Management Training	 Coverage varies $20	 Coverage varies $20
Acupuncture / Chiropractic *(Limited to combined 20 visits/calendar yr)*	$15 / visit	40%

Medical

Medical Benefits	PORAC PPO	
	In Network	Out of Network
Calendar Year Deductible	$300 indiv / $900 family	$600 indiv / $1,800 family
Maximum Calendar Year Co-pay *(excl. pharmacy)*	$3,000 indiv / $6,000 family	$3,000 indiv / $6,000 family
Hospitalization *(incl. Mental Health and Substance Abuse)* Deductible Inpatient/Outpatient	 N/A 10%	 N/A 10%
Emergency Room Deductible Emergency Room Co-pay *(inpatient or observation as outpatient)* Non Emergency Co-pay *(inpatient or observation as outpatient)*	N/A 10% 50%	N/A 10% 50%
Physician Services *(incl. Mental Health & Substance Abuse)* Office Visit Copay Inpatient Outpatient/Urgent Care	 $20 / visit 10% 10%	 10% 10% 10%
Diagnostic X-Ray / Lab	10%	10%
Prescription Rx: Retail *(up to a 30 day supply only)* Generic / Brand Name / Non-formulary	$10 / $25 / $45	100% up-front cost; paper claim may be submitted to request partial reimb.
Prescription Rx: Retail Maintenance Medications / Mail Order Pharmacy *Retail: taken for 60 days or more not to exceed 30 day supply; Mail Order: not to exceed 90 days supply for maintenance drugs* Generic / Brand Name / Non-formulary	$20 / $40 / $75	N/A
Max. co-pay/person per calendar yr	N/A	N/A
Durable Medical Equipment	20%	20%
Infertility Testing/Treatment	50%	50%
Occupational/Physical/Speech Therapy	10% (inpatient) / $20 (outpatient)	10% (inpatient) / 10% (outpatient)
Diabetes Services Glucose Monitoring Self-Management Training	 Coverage varies $20	 Coverage varies $20
Acupuncture / Chiropractic *(Limited to combined 20 visits/calendar yr)*	$20/visit *(10% for all other acupuncture services)*	10% acupuncture $35/visit chiropractic

Note: The PORAC PPO plan is only available to PSMA, PSOA and COA employees.

Medical



Compare 2018 Health Plans

my|CalPERS can help you choose a health plan with the new Find a Medical Plan tool.

Create a customized plan search to review:

- Monthly premiums for each plan
- Side-by-side comparisons of covered benefits, deductibles, and co-payments

To compare health plans, log in to your my|CalPERS account at my.calpers.ca.gov, select the "Health" tab and then select "Find a Medical Plan."

Medicare and the Active Worker

If you are an active employee and have reached the age of 65, you may be wondering about Medicare. You should receive an advisory notice from Medicare about four (4) months before your 65th birthday for your initial enrollment period. Here is some information that you should know about your Medicare options when working beyond age 65:

- When you reach age 65, if you continue to be an active employee with the City covered under our medical plans, you do not need to complete any paperwork at that time.
- You must stay in the Group Health medical plan until you retire or are otherwise not eligible for the group plan.
- You have the option of enrolling in Medicare Part A (hospital) coverage, which is typically premium-free. You may also enroll in Part B (medical) coverage at your cost. If you do so, your Group Health medical plan remains your primary and Part B (Medical Insurance), which does have a fee involved, would coordinate as secondary coverage to your Group Health medical plan. *Employees more typically enroll in Part A and defer Part B until retirement.*
- If you retire with the City and are eligible to continue your medical coverage, you must sign up for Part A and Part B with Medicare during the eight (8) months following the month that your health plan coverage or employment ended (whichever is first), also known as the Special Enrollment Period. At this time, ask for the Request for Employment Information form (CMS-L564) to be completed by the City to certify you have been covered under a group health plan. You will also need to complete the Certification of Medicare Status form to submit to CalPERS.
- If you choose to defer Part B after retirement, be aware there may be a 10% Federal surcharge added to the monthly premium for every 12 month period you were qualified to sign up for Medicare but did not enroll, if you were not covered by a Group Health medical plan.
- Upon retirement, CalPERS requires you enroll in Medicare Parts A & B, and will transition you to a supplement to Medicare plan (or terminate your insurance should you not enroll in Medicare), assuming that you meet other eligibility requirements.

For additional information on Medicare and your options, contact the Department of Human Resources at (408) 730-7490 or go to www.medicare.gov.

Dental

Under the Delta Dental Preferred Provider Organization (PPO) plan, dental services are provided through the Delta Dental PPO network. However, you can visit dentists inside or outside the network. What you pay depends on whether you choose a participating dentist. If you choose a non-participating dentist, you pay the difference between the amount the dentist receives from Delta Dental (the "allowable amount") and the dentist's charges.

You may also choose to visit a Delta Dental *Premier* provider. Premier dentists may not bill above Delta Dental's allowable amount, so your out-of-pocket costs may be lower than with a non-participating dentist. Your costs are usually lowest when you visit a Delta Dental PPO dentist. Pre-authorization from Delta Dental is recommended for charges of $250 or more.

SEA/Confidential, SEIU, SMA, PSMA, Unrepresented Management, Department Directors

Dental Benefits	Delta Dental PPO Core		Delta Dental PPO Buy up	
	In-Network	Out-of-Network*	In-Network	Out-Of-Network*
Calendar Year Deductible	$50 indiv / $150 family		**None**	$50 indiv /$150 family
Annual Plan Maximum	$1,100	$1,000	**$1,600**	**$1,500**
Diagnostic & Preventive	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Basic Services				
Fillings	Plan pays 80%	Plan pays 80%	Plan pays 80%	Plan pays 80%
Root Canals	Plan pays 80%	Plan pays 80%	Plan pays 80%	Plan pays 80%
Periodontics	Plan pays 80%	Plan pays 80%	Plan pays 80%	Plan pays 80%
Major Services	Plan pays 75%	Plan pays 75%	Plan pays 75%	Plan pays 75%
Orthodontic Services				
Orthodontia**	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%
Lifetime Maximum	$1,000	$1,000	**$1,500**	**$1,500**
Dependent Children	Covered to age 23	Covered to age 23	Covered to age 23	Covered to age 23

*Non-Delta Dentists are reimbursed at the lesser of the submitted charge or the fee that satisfies the majority of dentists in the same geographical area with the same training (51st percentile of Usual, Customary and Reasonable)

**Orthodontic benefit can be prorated based on number of treatment months. Please see HR for more information.

Dental

DeltaCare USA provides you and your family with quality dental benefits and is designed to encourage you to visit the dentist regularly to maintain your dental health. When you enroll, you select a contract dentist to provide services. Your dentist will take care of your dental care needs. If you need treatment from a specialist, your dentist will handle the referral for you.

Note: Dental services that are not performed by your selected contract dentist, or are not covered under provisions for emergency care, must be preauthorized by Delta Dental to be covered under your DeltaCare USA plan.

Under the DeltaCare USA plan, many services are covered at no cost, while others have copayments. See the "*Description of Benefits and Copayments*" for a detailed list of benefits.

SEA/Confidential, SEIU, SMA, PSMA, Unrepresented Management, Department Directors

Dental Benefits	DeltaCare USA DHMO
	In-Network
Calendar Year Deductible	$0
Annual Plan Maximum	Unlimited
Diagnostic and Preventive	$0-$10 copay* (varies by services; see contract for fee schedule)
Basic Services	
Fillings	$0-$420 copay* (varies by services; see contract for fee schedule)
Root Canals	$0-$140 copay* (varies by services; see contract for fee schedule)
Periodontics	$0-$150 copay* (varies by services; see contract for fee schedule)
Major Services	$0-$160 copay* (varies by services; see contract for fee schedule)
Orthodontic Services	
Orthodontia	$1,600-$1,800 copay (see contract for fee schedule)
Lifetime Maximum	Unlimited
Dependent Children	Covered to age 19

**The copay for each service is based upon the diagnostic codes determined by the American Dental Association (ADA). Please consult the Description of Benefits and Copayments for the actual copay amount based on the ADA diagnostic codes for each procedure. Limitations may apply for some benefits; some services may be excluded. Please refer to your Evidence of Coverage or Summary Plan Description for waiting periods and a list of benefit limitations and exclusions.*

Vision

You are eligible for vision coverage through Vision Service Plan (VSP). VSP provides coverage for eye exams and materials, such as lenses and frames.

Vision	VSP Vision		VSP Vision Buy-Up	
	In-Network	Out-of-Network	In-Network	Out-Of-Network
Examination				
Benefit	$15 copay	up to $50	$15 copay	up to $50
Frequency	1 x every 12 months	In-network limitations apply	1 x every 12 months	In-network limitations apply
Materials	$15 copay	See schedule below	$15 copay	See schedule below
Eyeglass Lenses				
Single Vision Lens	Fully Covered	Up to $50	Fully Covered	Up to $50
Bifocal Lens*	Fully Covered	Up to $75	Fully Covered	Up to $75
Trifocal Lens*	Fully Covered	Up to $100	Fully Covered	Up to $100
Frequency	1 x every 24 months	In-network limitations apply	**1 x every 12 months**	In-network limitations apply
Frames				
Benefit	$120 allowance	Up to $70	**$130 allowance**	Up to $70
Frequency	1 x every 24 months	In-network limitations apply	1 x every 24 months	In-network limitations apply
Contacts (Elective)**				
Benefit	Up to $120 (copay waived; instead of eyeglasses)	Up to $105 (in-network limitations apply)	**Up to $130** (copay waived; instead of eyeglasses)	Up to $105 (in-network limitations apply)
Frequency	1 x every 24 months	In-network limitations apply	**1 x every 12 months**	In-network limitations apply

**No-lined lenses are not a covered benefit under this plan. When requested, the lenses will be covered up to the value of the lined lenses and you will pay the additional cost.*
***When you choose contacts instead of glasses, your $120/$130 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts.*

Note: You may receive benefits when using non-VSP providers by submitting your claims directly to VSP. Reimbursements will be made as indicated in the out-of-network schedule above. Find a VSP network doctor at www.vsp.com or call (800) 877-7195.

Basic Life and AD&D Insurance

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security and pay for large expenses such as housing and education, as well as day-to-day living expenses.

BASIC LIFE AND AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by the City of Sunnyvale. Coverage is provided by Voya Financial.

Class	Description	Benefit
Class 1	City Manager / City Attorney	1x Basic Annual Earnings to $325,000
Class 2, 4	All Management Employees	1x Basic Annual Earnings to $175,000
Class 3	All Other Full-Time Employees	1x Basic Annual Earnings to $175,000
Class 5	SEIU Employees	1x Basic Annual Earnings to $80,000

Note: The Internal Revenue Code (IRC) requires that premiums paid by the City for Basic Life insurance coverage in excess of $50,000 be included as taxable income at the close of each tax year. You will see the taxable value included in your income on your paycheck and W-2. This will most likely not impact your tax status, but you may wish to consult with your financial planner.

Conversion: Upon separation or retirement, your Basic Life coverage may be converted to a Whole Life policy with Voya. Rates per $1,000 in coverage are based on your age. You will need to complete and submit a *Life Conversion Information Request* form, along with payment, to the insurance carrier within 31 days of leaving City employment. Please contact the Department of Human Resources to obtain this form.

Supplemental Life and AD&D Insurance

Supplemental Life and AD&D Insurance allows you to elect additional life insurance to protect your family's financial security. Depending on your bargaining unit, the City's cafeteria contribution may or may not be used to cover your supplemental life premiums.

The amount available varies by class. Coverage is provided by Voya Financial.

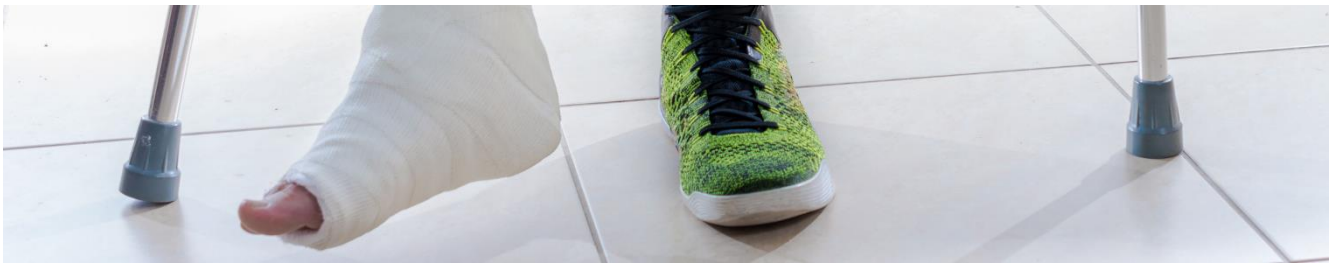
Class	Description	Benefit	Guarantee Issue[1]
Class 1	City Manager/City Attorney	1X Basic Annual Earnings to $250,000	$250,000
Class 2	Grandfathered Management Employees (enrolled before 12/31/2011 and did not elect Class 4 coverage for 2012)	1x Basic Annual Earnings to $175,000 (not to exceed $175,000 Basic and Supplemental Life combined)	$175,000
Class 3	All Other Eligible Employees	1x Basic Annual Earnings to $175,000 (not to exceed $175,000 Basic and Supplemental Life combined)	$175,000
Class 4	All Management Employees	1x Basic Annual Earnings to $250,000	$250,000
Class 5	SEIU Employees	1x Basic Annual Earnings to $80,000 (not to exceed $80,000 Basic and Supplemental Life combined)	$80,000

[1]Guaranteed Issue: Supplemental life and AD&D coverage is guaranteed *only* for new hires and those newly eligible for this benefit. If you seek to elect coverage in the future, your application will be subject to approval by the insurance carrier (a process known as underwriting) and you will need to complete the Evidence of Insurability (EOI) form.[1]

Age Reduction(s): Benefit amounts reduce to 65% of original coverage at age 70, to 45% at age 75, to 30% at age 80 and to 15% at age 85.

Continuation: Upon separation or retirement, your Supplemental life insurance may be taken with you. You will need to complete and submit a *Term Life Coverage Continuation Request* form, along with payment, to the insurance carrier within 31 days of leaving City employment. Please contact the Department of Human Resources to obtain this form.

Disability Insurance



If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

LONG-TERM DISABILITY INSURANCE (LTD)

When an illness or injury makes it impossible for you to work for an extended period of time, your income may be continued under the City of Sunnyvale's LTD Plan. The City pays the entire cost of coverage. Under the plan, if you are disabled for more than the designated elimination period, you could receive 67% of your salary (up to a maximum dollar amount per month) until you are able to return to work. Coverage is provided by Voya Financial.

Available to Full-Time Active Employees (excluding PSOA, who are covered by the Association)

LTD	Benefit
Eligibility	All Full-Time Active Employees (excluding PSOA Employees)
Monthly Benefit Amount	Plan pays 67% of covered monthly earnings
Maximum Monthly Benefit	$14,000 – City Manager $12,000 – City Attorney $11,000 – Department Directors and All Other Employees
Minimum Monthly Benefit	$100
Benefits Begin After:	
Accident	90 days of disability
Sickness	90 days of disability
Maximum Payment Period*	To age 65

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

Flexible Spending Accounts (FSA)

Flexible Spending Accounts (FSA) are a great way to use pre-tax dollars to pay for expenses normally paid with after-tax dollars! The City offers three types of flexible spending accounts:

Account	Description	Maximum Election
Healthcare	Use pre-tax dollars to pay for eligible medical, dental, vision, prescription and over-the-counter costs	$2,400 per Plan Year *(election may only be made or modified upon hire, during annual open enrollment or due to a qualifying event)*
Dependent Care	Use pre-tax dollars to pay for eligible childcare, after school care, day camp or nursery school for children under age 13 (or mentally or physically incapable dependents over age 13)	$5,000 per household per Plan Year *(election may only be made or modified upon hire, during annual open enrollment or due to a qualifying event)*
Transit	Use pre-tax dollars to pay for public transit, including train, subway, bus, vanpool, parking and park-and-ride expenses.	Up to $255 per month for mass transit or van pooling costs *(election may be made, modified or discontinued any month during the year)*

All of our Flexible Spending Accounts are administered by Payflex. These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts, reducing your taxable income. Pre-tax means the dollars you allocate toward these accounts are not subject to Medicare tax, Federal income tax and, in most cases, state and local taxes. The money you set aside may be used for qualified eligible expenses on a pre-tax basis.

At enrollment, you determine the amount of money to contribute to these accounts for the plan year. The contributions are deducted pre-tax per pay period from your paycheck and deposited into the FSA account(s). You request reimbursement of qualified expenses as you incur the expenses from your FSA account(s).

Flexible Spending Accounts (FSA)

HEALTHCARE FSA

The maximum amount you may contribute to the Healthcare Spending Account under the City's plan for each Plan Year is **$2,400**. This account can be used to reimburse you using pre-tax money for qualified out-of-pocket healthcare expenses not covered under your healthcare plans. Out-of-pocket healthcare expenses eligible for reimbursement may include, but are not limited to, copays and deductibles for medical, dental, vision and pharmacy services.

The 2018 Healthcare Spending Account can only be used to reimburse for costs incurred through the end of the Plan Year (December 31, 2018), but you have until March 31, 2019 to submit for reimbursement of these 2018 expenses. Please note that it is important that you carefully consider and choose the right annual election amount for you. If you have more than $50 remaining in your 2018 Healthcare Spending Account after March 31, 2019, balances of up to $500 will be automatically rolled over into your 2019 Healthcare Spending Account. Any amounts below $50 or over $500 will be forfeited to the Plan.

TIPS FOR YOUR HEALTHCARE FSA…

- **Submitting for reimbursement:**
  - *Payflex Mobile app*: Manage your account, view alerts, snap a photo of your receipts to submit claims. App is available for iPhone and Android.
  - *Payflex online*: Scan and upload receipts and submit claims via the online portal.
- **Reimbursement options:**
  - *Pay yourself*: Pay for eligible expenses yourself with cash, check or personal credit card. Then submit a claim to pay yourself back. Payflex can issue you a check or, better yet, reimburse you via direct deposit.
  - *Pay your provider*: Use Payflex online to pay your provider directly.
- **FSAs have a use-it-or-lose-it rule:** While we offer a rollover provision as noted above, funds below $50 or over $500 will be forfeited if not used.
- **Other requirements:** You can change your contribution mid-year if you have a qualifying change in status (e.g. marriage, employment status, number of tax dependents, etc.).

Healthcare FSA	
2018 Limit:	$2,400
Dates to incur claims:	January 1, 2018 – December 31, 2018
Last date to submit for reimbursement:	March 31, 2019

Flexible Spending Accounts (FSA)

DEPENDENT CARE FSA

Eligible expenses may include daycare centers, in-home child care, 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.

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.

ELIGIBLE DEPENDENTS INCLUDE:

- Dependent child under age 13 (as defined by the IRS).
- Your legal spouse/registered domestic partner, or other dependent, who is not mentally or physically capable to care for themselves, and lives with you for more than half of the year.

The 2018 Dependent Care Spending Account can only be used through the end of the Plan Year (December 31, 2018), but you have until March 31, 2019 to submit claims for expenses incurred prior to the end of the Plan Year. Please note that it is important that you carefully consider and choose the right annual election amount for you. Any unused balance remaining in your 2018 Dependent Care Spending Account after March 31, 2019 will be forfeited to the Plan.

TIPS FOR YOUR DEPENDENT CARE FSA…

- **Submitting for reimbursement:**
  - *Payflex Mobile app*: Manage your account, view alerts, snap a photo of your receipts to submit claims. App is available for iPhone and Android.
  - *Payflex online*: Scan and upload receipts and submit claims via the online portal.
- **Other requirements***:* To use funds, you must be working. If you're married, your spouse must be working, looking for work, a full-time student or incapable of self-care.
- **Mid Year Changes:** You can change your contribution if you have a qualifying change in status, or a change in provider cost (e.g. marriage, employment status, # of tax dependents, etc.).

Dependent Care FSA	
2018 Limit:	$5,000 per household
Dates to incur claims:	January 1, 2018 – December 31, 2018
Last date to submit for reimbursement:	March 31, 2019

Flexible Spending Accounts (FSA)

TRANSPORTATION SPENDING ACCOUNT (TSA)

PayFlex offers a *Commuter Reimbursement Program* which gets you to work while saving you money. With this program, you pay for your commuting costs with pre-tax dollars up to the monthly IRS limit of $255 per month. This means you don't pay federal income or Medicare taxes on this money, lowering your taxable income.

Which expenses are eligible?

Expenses are limited to eligible commuter parking and mass transit expenses you incur. Expenses for your spouse or dependents are not reimbursable under this program.

What are examples of eligible expenses?

Examples of eligible expenses include a paid parking facility at or near your workplace, commuter trains, buses and vanpooling. The eligible amounts are limited to actual out of pocket expenses up to the government-imposed limits.

How do I get started?

Notify the Employee Benefits division that you want to enroll. You will then be able to go to www.payflex.com and register your account. From your account, you can order transit and parking passes, vouchers, commuter checks and more! Both electronic and paper delivery options are available. Other benefits of setting up an online account include:

- *Pay Your Parking Provider Online*: Through your online account, you can schedule your parking payment to occur automatically each month.
- *Schedule Your Purchase to Occur Automatically*: You can have your monthly pass(es) automatically purchased without having to go online each month.

TIPS FOR YOUR COMMUTER BENEFITS FSA:

- You may elect, modify or cancel your enrollment in this account throughout the year (see below). Unlike the other FSAs offered, this account is more flexible.
- Make sure to order your passes prior to the cutoff date (the 5th of the previous month). You can also cancel a pass before the cutoff date.
- You may buy more than the IRS pre-tax limit. Any excess costs will be charged to you on an after-tax basis.
- Keep your passes in a safe place. If you lose your pass you cannot obtain a refund.
- PayFlex will replace up to one non-delivered pass per plan year. You must complete the Transit Non-Delivered Pass form found on www.payflex.com prior to the monthly deadline.

Other Programs

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP) is designed to help with short-term counseling needs. It offers quick and easy access to confidential, professional assistance and resources to help you and your family address difficulties related to emotional, relationship, substance abuse, legal and financial concerns.

If it is determined that more than seven (7) sessions are needed for your specific situation, the EAP will help coordinate your needs under your medical plan. All services are confidential and in accordance with professional ethics and Federal and State laws. Use of the EAP is strictly voluntary.

Work & Life Services: Depending on your plan, telephonic consultation may be available for:

- Child and Eldercare Assistance – Help accessing available community and financial resources and referrals to pre-screened providers for childcare, eldercare and more. You may also be entitled to help with adoption, parenting skills, child development, special needs, emergency care, relocation services and educational issues.
- Financial Issues – Budgeting, credit and financial guidance (tax or investment advice, loans and bill payments not included).
- Federal Tax Assistance – Help with IRS audits and unfiled or past-due tax returns (not a tax representation or preparation service).
- Pre-Retirement Planning – Guidance for planning a quality retirement (does not include investment, tax or legal advice).
- Organizing Life's Affairs – Help organizing records and final details for a loved one.
- Concierge Services – Referrals for everyday errands, travel, event planning and more
- Legal Services – Telephonic or face-to-face legal consultations for issues relating to civil, consumer, personal and family law, financial matters, business law, real estate, criminal matters, the IRS and estate planning (excluding disputes or actions between members and their employer or MHN).

Questions? MHN EAP services are accessible 24-hours a day
(800) 242-6220 • www.members.mhn.com • Company Code: sunnyvale

Other Programs

CALPERS RETIREMENT

The City has contracted with CalPERS to provide retirement benefits and medical coverage after you retire. To be eligible for service retirement, you must be at least age 50 (or 52 for Miscellaneous members subject to Public Employees' Pension Reform Act (PEPRA)) and have a minimum of 5 years of CalPERS-credited service. To be eligible for retiree medical coverage, your CalPERS retirement date must be within 120 days of separation from the City.

Three factors are used to calculate your retirement benefits:

- Service credit – It accumulates on a fiscal year basis from July 1 through June 30
- Benefit factor – This is determined by your age at retirement and retirement formula that is contracted for your employee group.
- Final highest year (12 consecutive months average, or 36 months average for members subject to PEPRA) of compensation

Who is Eligible For Coverage?

All regular full-time and part-time employees, and casual employees who are pre-existing CalPERS members.

When Are You Eligible For Coverage?

The first day of your employment.

If you have questions or comments regarding the CalPERS retirement plan, please contact the Department of Human Resources at (408) 730-7490.

Other Programs

457 DEFERRED COMPENSATION PLAN

The 457 Deferred Compensation Plan is designed for long term supplemental retirement savings, which is governed by the Internal Revenue Code (IRC) 457. This is a voluntary payroll deduction plan. You may elect to defer a portion of your wages into the plan. Contributions and earnings remain tax-deferred while in the plan, and are not taxable until distributed.

You may defer from $10 to 100% of your wages per pay period, up to the annual maximum amount indexed under the IRC. If you are age 50 or over, or within 3 years of retirement, you may be eligible for an additional catch-up contribution.

2018 basic contribution limit	Up to current IRS annual limit
2018 age 50 catch-up limit	Up to current IRS annual limit *(in addition to the basic contribution limit)*
2018 3-year pre-retirement catch-up limit	Up to current IRS annual limit *(in addition to the basic contribution limit)*

Who is Eligible

All regular full-time and part-time employees are eligible to participate. Contributions can begin with the first pay of the month following your date of hire.

When Can You Make Changes to Your Benefits

In accordance with the Internal Revenue Code, contribution changes will be effective no earlier than the first pay of the calendar month following the date a contribution change form is received by the Department of Human Resources.

Provider

The City offers three providers:

- ICMA Retirement Corporation
- Nationwide Retirement Solutions
- CalPERS 457 Deferred Compensation Program

You may participate with more than one provider. However, the annual maximum contribution applies to all contributions made in all 457 plans combined. Also, if you are a new employee, your 457 contributions through a previous employer(s) plus your contributions through the City of Sunnyvale, may not exceed the annual maximum contribution combined.

If you have questions regarding the Deferred Compensation Plan, please contact the Department of Human Resources at (408) 730-7490.

Other Programs

401(A) DEFINED CONTRIBUTION PLAN

The 401(a) Defined Contribution Plan allows an additional opportunity to tax shelter contributions on a pre-tax and after-tax basis, governed by the Internal Revenue Code (IRC) 415. The 401(a) is a long-term supplemental retirement savings plan.

Only designated eligible groups of employees can participate in the plan. The pre-tax contribution is a fixed mandatory contribution. An after-tax contribution is on a voluntary basis. In addition, the City contributes a fixed 2% to the eligible group of employees.

The contribution limit is higher for this plan. The annual maximum contribution includes the mandatory pre-tax contribution, the voluntary after-tax contributions, and the City's contribution.

2018 contribution	Up to current IRS annual limit

Who is Eligible

Only newly hired management employees are eligible to participate. There is a 60-day election window from your date of hire. Your election to enroll or not is irrevocable, and becomes effective at the end of the election window.

When Can You Make Changes to Your Benefits

The mandatory pre-tax contribution cannot be changed. In addition, you cannot cease to participate once you are enrolled. If you elect not to participate during the 60 day election period, you cannot enroll in the future. Participation is an irrevocable decision.

You may change your voluntary after-tax contribution anytime.

If you elect not to participate in this plan, or before you enroll in the 401(a) plan during the 60-day waiting period, the 2% City contribution will be made to your 457 plan.

Provider

ICMA Retirement Corporation is the sole provider of the 401(a) plan.

If you have questions regarding the Deferred Compensation Plan, please contact the Department of Human Resources at (408) 730-7490.

Plan Contacts

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

Anthem Blue Cross Select and Traditional HMO	
Member Services	(855) 839-4524
Group Number	#HTB050B (Traditional) #HNB050B (Select)
Website	www.anthem.com/ca/calpers

Anthem Blue Cross Select, Choice, Care PPO	
Member Services	(877) 737-7776
Group Number	#SB050K (PERS Select) #CB050K (PERS Choice) #KB050K (PERSCare)
Website	www.anthem.com/ca/calpers

Anthem Blue Cross PORAC PPO	
Member Services	(800) 288-6928
Group Number	#13079G
Website	www.ibtofporac.org

Blue Shield Access+ HMO	
Member Services	(800) 334-5847
Group Number	#ITB010B (Access+)
Website	www.blueshieldca.com/calpers

HealthNet SmartCare HMO	
Member Services	(888) 926-4921
Group Number	JNB050C
Website	www.healthnet.com/calpers

Kaiser Permanente HMO	
Member Services	(800) 464-4000
Group Number	#00003-20
Website	www.kp.org/ca/calpers

UnitedHealthcare Alliance HMO	
Member Services	(877) 359-3714
Group Number	#246320
Website	www.uhc.com/calpers

Western Health Advantage	
Member Services	(888) 942-7377
Website	www.westernhealth.com/calpers

Delta Dental of California	
Member Services	(800) 765-6003 (PPO) (800) 422-4234 (DHMO)
Group Number	#10933 (PPO) #05360 (DHMO)
Website	www.deltadentalins.com

VSP	
Member Services	(800) 877-7195
Group Number	12137687
Website	www.vsp.com

Plan Contacts

Payflex	
Member Services	(800) 284-4885
Group Number	128934
Website	www.payflex.com

CalPERS Retirement	
Member Services	(888) 225-7377
Website	www.calpers.ca.gov

Payflex (FSA)	
Member Services	(800) 284-4885
Group Number	128934
Website	www.payflex.com

CalPERS 457 Deferred Compensation	
Member Services	(800) 260-0659
Group Number	#450217
Website	http://calpers.voya.com

ICMA 457 Deferred Compensation	
Member Services	(800) 669-7400
Group Number	#300634 (457) #107774 (401a)
Website	www.icmarc.org

Nationwide 457 Deferred Compensation	
Member Services	(800) 769-4457
Group Number	#41614001
Website	www.nrsforu.com

Voya (Life & Disability)	
Member Services	(800) 955-7736
Group Number	#31640-7
Website	www.voya.com

MHN (EAP)	
Member Services	(800) 242-6220
Group Number	#5016
Website	members.mhn.com Company Code: sunnyvale

Words You Need to Know

Health insurance seems to have its own language. You will get more out of your plans if understand the most common terms, explained below in plain English.

MEDICAL

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.

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.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

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. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred 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 not on the preferred drug list may not be covered.

DENTAL

BASIC SERVICES - Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTIC AND PREVENTIVE SERVICES - Generally include routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES - Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Important Plan Notices and Documents

The following pages include mandatory notices that all employers are required to provide to their employees. The contents of the notices may or may not apply to you. If you have any questions, please contact the Department of Human Resources at (408) 730-7490.

MEDICARE PART D NOTICE

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

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Sunnyvale and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. City of Sunnyvale has determined that the prescription drug coverage offered by the City of Sunnyvale is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

Important Plan Notices and Documents

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 City of Sunnyvale coverage **will** 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:** Retiree CalPERS coverage includes enrollment in a Medicare Part D plan. Do not enroll in a non-CalPERS Medicare Part D plan or your CalPERS Medicare health plan coverage will be terminated.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

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

FOR MORE INFO ABOUT 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.

Important Plan Notices and Documents

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:	August 31, 2017
Name of Entity:	City of Sunnyvale
Contact:	Employee Benefits Division of Human Resources
Address:	505 W. Olive Avenue, Suite 200, Sunnyvale, CA 94086
Phone Number:	(408) 730-7490

Important Plan Notices and Documents

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. For further details, please refer to the Plan's Summary Plan Description.

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 (408) 730-7490.

Important Plan Notices and Documents

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in City of Sunnyvale 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 City of Sunnyvale 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 City of Sunnyvale 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 rights, 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 City of Sunnyvale describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting City of Sunnyvale.

Important Plan Notices and Documents

NOTICE OF CHOICE OF PROVIDERS

HMO plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. Until you make this designation, your carrier will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carrier directly.

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

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

MICHELLE'S LAW

The City of Sunnyvale plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, please notify the Employee Benefits Division of Human Resources as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

Important Plan Notices and Documents

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 below, contact your State Medicaid or CHIP office to see 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, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Ins. Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507

Important Plan Notices and Documents

ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

Important Plan Notices and Documents

MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthipprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473

Important Plan Notices and Documents

TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

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

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

PAPERWORK REDUCTION ACT STATEMENT

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

Important Plan Notices and Documents

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

ADDITIONAL INFORMATION REGARDING YOUR BENEFITS

New Health Insurance Marketplace Coverage Options

Part A: General Information

Health care reform created a new way to buy private individual health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage we offer to you. Please note that this notice is informational only.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find private individual health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November 15, 2014 for coverage starting January 1, 2017.

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

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

Does the Employment-Based Health Coverage We Offer to You Affect Your Eligibility for Premium Savings through the Marketplace?

Yes. If we have offered you health coverage that meets certain standards, you will not be eligible for a tax credit through the Marketplace and you may wish to enroll in our health plan, if you are eligible. (Just because you received this Marketplace notice does not mean you are eligible.) However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if we do not offer coverage to you at all or do not offer coverage that meets certain standards.

Important Plan Notices and Documents

If the cost of self- only coverage under our health plan is more than 9.5% of your household income for the year, or if our health plan does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

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

[1] *An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.*

Part B: Information About Employer-Provided Health Plan Coverage

If you decide to complete an application for coverage in the Marketplace, you will be asked for information about our health plan coverage. The information below can help you complete your application for coverage in the Marketplace.

1. General Employer Information

Employer Name:	City of Sunnyvale
Employer Identification Number (EIN):	946-000-438
Employer Street Address:	505 West Olive Avenue, Suite 200
Employer Phone Number:	(408) 730-7490
Employer City:	Sunnyvale
Employer State:	California
Employer ZIP Code:	94086
Who Can We Contact About Employee Health Coverage At This Job?	Employee Benefits Division of the Human Resources Department
Phone Number (if different from above):	Same as above
Email Address:	N/A

Important Plan Notices and Documents

2. Eligibility. You may be asked whether or not you are currently eligible for our health plan coverage or whether you will become eligible for coverage within the next three months. In addition, if you are or will become eligible, you may be required to list the names of your dependents that are eligible for coverage under our health plan.

If you would like information about the eligibility requirements for our health plan, please read the eligibility provisions described in the Summary Plan Description for our health plan. You can obtain a copy of the Summary Plan Description by contacting the Department of Human Resources at (408) 730-7490.

3. Minimum Value. If you are eligible for coverage under our health plan, you may be required to check a box indicating whether or not our health plan meets the minimum value standard. Our health plan coverage meets the minimum value standard.

4. Premium Cost. If you are eligible for coverage under our health plan, you may be asked to provide the amount of premiums you must pay for self-only coverage under the lowest-cost health plan that meets the minimum value standard. If you had the opportunity to receive a premium discount for any tobacco cessation program, you must enter the premium you would pay if you received the maximum discount possible for a tobacco cessation program.

If you would like information about the premiums for self-only coverage under our lowest-cost health plan, please contact the Department of Human Resources at (408) 730-7490.

5. Future Changes. You may also be asked whether or not we will be making certain changes to our health plan coverage for the new plan year. As usual, you will be provided with information about any changes to our health plan coverage before the next open enrollment period. If you are not sure how to answer this question on your Marketplace application, please contact the Marketplace.

Notes

Sunnyvale

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