2024

Benefits Overview Guide

CITY OF SAN JOSE
CAPITAL OF SILICON VALLEY

Benefit Driven. Wellness Focused.

WHAT'S NEW, WHAT TO DO

01/01/2024 – 12/31/2024

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BENEFIT DRIVEN. WELLNESS FOCUSED.

The benefits in this summary are effective: January 1, 2024 - December 31, 2024

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 Annual Notices for more details.

At the City of San José, we value your contributions 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.

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 benefit booklets determine how all benefits are paid.

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

Who Can You Cover?

WHO IS ELIGIBLE?

Full-time and part-time benefited employees are eligible for benefits described in this handbook unless otherwise noted in specific sections, the employee's MOA, Benefits & Compensation summaries, or plan documents.

You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your same or opposite sex domestic partner is eligible for coverage if you have completed a Domestic Partner Declaration. Please review the affidavit guidelines. The Cost of Coverage section explains the tax treatment of domestic partner coverage.
- Your children (including your domestic partner's children):
    - Under age 26 are eligible to be enrolled in medical and EAP coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 ONLY if they are incapacitated due to a disability and are primarily dependent on you for support.
    - Under age 24 are eligible to be enrolled in dental and vision coverage.
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined

WHO IS NOT ELIGIBLE?

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

- Parents, grandparents, and siblings.
- Any individual who is covered as an employee of City of San José cannot also be covered as a dependent.
- Employees who work fewer than 20 hours per week, temporary employees who work fewer than 20 hours per week, contract employees, or employees residing outside the United States.

ENROLLMENT PERIODS

Coverage for new or promoting employees will be effective the first of the month following the employee's enrollment date. New or promoting employees will have 30 days from date of promotion or date of hire (Eligibility Date) to enroll in benefit plans.

New or promoting employees who do not complete the enrollment process within 30 days will automatically be enrolled in the Anthem $1500 Deductible Select HMO employee only level for medical, and the DeltaCare HMO employee only level for dental.

After that, Open Enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Mid-Year Changes

Other than during the annual "open enrollment" period, you may not change your coverage unless you experience a qualifying event. Qualifying events include:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, registration or dissolution of domestic partnership, and 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
- Permanent change in work schedule, including a significant 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 special enrollment event under HIPAA (**the Health Insurance Portability and Accountability Act), 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!—THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

- Any changes you make must be consistent with the change in status,
- You must make the changes within 30 days of the date the *event* (marriage, birth, etc.) occurs,
- With the exception of births, life events take effect the first of the following month after the life event effective date.

. **The** information in this booklet is a general outline of the benefits offered under the City of San José benefits program. This booklet may not include all relevant limitations and conditions. Specific details and limitations are provided in the plan documents, which may include a Summary of Plan Description (SPD), Evidence of Coverage (EOC), and/or insurance policies. The plan documents contain relevant plan provisions. If the information in this booklet differs from the plan documents, the plan documents will prevail.

Mid-Year Changes

LIFE EVENTS: MID-YEAR BENEFIT CHANGES

Log into eWay to initiate mid-year benefit changes outside your new hire/newly eligible event or annual open enrollment. i.e. To request changes to your own or dependent's benefit coverage due to a qualifying life event, such as change in marital status, birth or placement of a child, and/or change of benefit eligibility.

- Life Event benefit changes must be summited in eWay within 30 days of the qualifying life event.
- Required proof of event and dependents must be uploaded in eWay or provided within 60 days.
- **Life Events Reference Guide**- a simple guide that lists out the steps by life event and what documents you will be asked to upload.
- For more detailed step-by-step instruction, please refer to the **Life Event Guide.**
- Once your life event changes are submitted, please be sure to review the **Life Event Checklist** to review and/or update other areas in eWay that may be impacted by your life event.

PLEASE NOTE:

You must e-mail HRBenefits@sanjoseca.gov with your Employee ID, Event Type, and Date of Event to have a special enrollment event opened **BEFORE** you proceed if you are currently in Health/Dental in Lieu or waived and intend to change to one of the City's plans OR currently in one of the City's Health/Dental plans and intend to change to an in-Lieu plan.

Medical

The City's medical plans are designed to help maintain wellness and protect you and your family from major financial hardships in the event of illness or injury. The City offers a choice of medical plans through **Anthem Blue Cross and Kaiser Permanente**.

WHICH PLAN IS RIGHT FOR YOU?

Consider an HMO (Health Maintenance Organization) if:	
• You want lower, predictable out-of-pocket costs • You like having one doctor manage your care • You are happy with the selection of network providers • You don't see any doctors that are out-of-network	Plans To Consider • Anthem $20 Copay Traditional HMO • Anthem $20 Copay Select HMO • Anthem $1500 Deductible Select HMO • Kaiser $25 Copay • Kaiser $1500 Deductible HMO

Consider a PPO (Preferred Provider Organization) if:	
• You want to be able to see any provider, even a specialist, without a referral • You want access to one of the largest national networks in the Country, with the ability to see any licensed provider in the nation, regardless of whether or not the provider is in the network	Plans To Consider • $100 Deductible Select PPO • $100 Deductible Classic PPO

Consider a High Deductible Health Plan (HDHP) if:	
• You want to be able to see any provider, even a specialist, without a referral (Not applicable for the Kaiser $3000 Deductible HMO Plan) • You are willing to pay more to see out-of-network providers (Not applicable for the Kaiser $3000 Deductible HMO Plan) • You want tax-free savings on your healthcare costs • You want to build a savings account for future healthcare costs for you and your eligible family members • You want an extra way to add to your retirement savings	Plans To Consider • Anthem $2500 Deductible Classic PPO w/ H.S.A. • Anthem $2500 Deductible Classic PPO w/o H.S.A. • Kaiser $3000 Deductible w/H.S.A • Kaiser $3000 Deductible w/o H.S.A

Medical

ANTHEM MEMBER EXCLUSIVE PERKS

Partnership with Santa Clara County IPA (SCCIPA)

Santa Clara County IPA is the largest network of independent physicians in the county with over 900 physicians throughout Santa Clara County. SCCIPA providers are focused on providing personalized care to each of their members.

Partnering with Anthem Blue Cross and the City of San José, SCCIPA is proud to provide a high performing network of independent physicians. SCCIPA members also can participate in the Care Concierge Program. If you have a hospital stay or a complex health condition, the SCCIPA team is there to help transition to home and follow your care through recovery.

SCCIPA provides:

- Direct 24-hour help line 24/7
- Enrolled patients receive a Local nurse as Concierge
- Personalized experience with proven health outcomes

ANTHEM CONCIERGE

Anthem members have access to a concierge exclusive to City of San José Anthem members!

Our Concierge service includes:

- Communicating the benefit design packages to members as defined by The City of San José through virtual 1x1s.
- Interacting with members in a multi-channel environment verbally (e.g., chat, telephone, face to face, video chat) and in written form to ensure appropriate engagement is achieved.
- Interpreting plan benefit design, resolving claim, benefit, and enrollment issues.
- Assisting in increasing member's engagement into appropriate Anthem programs and offerings.
- An additional resource and educator on health care related inquiries.
- Availability from Monday – Friday, 8am – 5pm.

Medical

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

NO DEDUCTIBLE HMO PLANS

	Anthem $20 Copay Traditional or Select HMO	Kaiser Permanente $25 Copay HMO
	In-Network	In-Network
Annual Deductible	$0 per individual $0 per family	$0 per individual $0 per family
Annual Out-of-Pocket Max	$1,500 per individual $3,000 family limit	$1,500 per individual $3,000 family limit
Office Visit		
Primary Provider	$20 copay	$25 copay
Specialist	$20 copay	$25 copay
Preventive Services	Plan pays 100%	Plan pays 100%
Chiropractic Care	$20 copay (up to 20 visits combined with rehab benefits)	Not covered
Lab and X-ray	No charge	No charge
Inpatient Hospitalization	$100 per admission	$100 per admission
Outpatient Surgery	$100 per visit	$100 per procedure
Urgent Care	$20 copay	$25 copay
Emergency Room	$100 per visit (copay waived if admitted)	$100 per visit (copay waived if admitted)
Prescription		
Retail (30-day supply)		
Generic	$10 per refill	$10 per refill
Preferred	$30 per refill	$25 per refill
Non-Preferred	$60 per refill	$25 per refill
Specialty Drug	$60 per refill	$25 per refill
Mail Order (90/100d supply)		
Generic	$20 per refill	$20 per refill
Preferred	$60 per refill	$50 per refill
Non-Preferred	$120 per refill	$50 per refill

Medical

DEDUCTIBLE HMO PLANS

	Anthem $1500 Deductible Select HMO	Kaiser $1500 Deductible HMO
	In-Network	In-Network
Annual Deductible		
Self Only Coverage	$1,500	$1,500
Family Coverage		
Each member	$1,500	$1,500
Entire Family of 2+	$3,000	$3,000
Annual Out-of-Pocket Max		
Self Only Coverage	$4,000	$4,000
Family Coverage		
Each member	$4,000	$4,000
Entire Family of 2+	$8,000	$8,000
Office Visit		
Primary & Specialist	$20 copay	$40 copay
Preventive Services	Plan pays 100%	Plan pays 100%
Chiropractic Care	$20 copay (up to 20 combined with rehab benefits)	Not covered
Acupuncture	$20 copay (up to 20 combined with rehab benefits)	Not covered
Lab and X-ray	$10 copay per procedure $50 copay per test (MRI/PET/CT)	$10 per encounter 30% up to $50 per test (MRI/PET/CT)
Inpatient Hospitalization	30% after deductible	30% after deductible
Outpatient Surgery	30% after deductible	30% after deductible
Urgent Care	$20 copay	$40 copay
Emergency Room	30% after deductible	30% after deductible
Prescription		
Retail (30-day supply)		
Generic	$10 per refill	$10 per refill
Preferred	$30 per refill	$30 per refill
Non-Preferred	$60 per refill	$30 per refill
Specialty Drug (30-day)	$60 per refill	$30 per refill
Mail Order (100-day supply)		
Generic	$20 per refill	$20 per refill
Brand Name/Formulary	$60 per refill	$60 per refill
Non-Formulary	$120 per refill	$30 per refill

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Medical

ANTHEM BLUE CROSS PPO PLANS

	Anthem $100 Deductible Select PPO		Anthem $100 Deductible Classic PPO	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible **Individual | Family**	$100 | $200		$100 | $200	
Annual Out-of-Pocket Max **Individual | Family**	$2,100 | $4,200		$2,100 | $4,200	
Office Visit				
Primary & Specialist	$25 copay	30% after deductible	$25 copay	30% after deductible
Preventive Services	Plan Pays 100%	30% after deductible	Plan Pays 100%	30% after deductible
Chiropractic Care (20 visits per calendar year)	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Acupuncture	10% after deductible	10% after deductible	10% after deductible	10% after deductible
Lab and X-ray	10% after deductible	30% up to $800 per test (MRI/PET/CT)	10% after deductible	30% up to $800 per test (MRI/PET/CT)
Inpatient Hospitalization	10% after deductible	30% after deductible	10% after deductible	30% after deductible
Outpatient Surgery	$100 copay per admission + 10%	30% after deductible	$100 copay per admission + 10%	30% after deductible
Urgent Care	$25 copay	30% after deductible	$25 copay	30% after deductible
Emergency Room	$100 per visit after deductible (waived if admitted)		$100 per visit after deductible (waived if admitted)	
Prescription				
Retail (30-day supply)				
Generic	$10 per refill	25% up to $250	$10 per refill	25% up to $250
Preferred	$25 per refill	25% up to $250	$25 per refill	25% up to $250
Non-Preferred/ Specialty	$40 per refill	25% up to $250	$40 per refill	25% up to $250
Mail Order (100-day supply)				
Generic	$20 per refill	Not Covered	$20 per refill	Not Covered
Preferred	$50 per refill	Not Covered	$50 per refill	Not Covered
Non-Preferred/ Specialty	$80 per refill	Not Covered	$80 per refill	Not Covered

Medical

HEALTH SAVINGS ACCOUNT (HSA) QUALIFIED PLANS.

	Anthem $2500 Deductible Classic PPO with HSA		Kaiser $3000 Deductible With HSA
	In-Network	**Out-of-Network**	**In-Network**
Annual Deductible			
Self Only Coverage	$2,500		$3,000
Family Coverage			
Each member	$3,200		$3,200
Entire Family of 2+	$5,000		$6,000
Annual Out-of-Pocket Max			
Self Only Coverage	$4,000	$9,000	$5,950
Family Coverage			
Each member	$4,000	$ 9,000	$ 5,950
Entire Family of 2+	$8,000	$18,000	$11,900
Office Visit	20% after deductible	40% after deductible	30% after deductible
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 100%
Chiropractic Care (30 visits per calendar year)	20% after deductible	40% after deductible	Not covered
Acupuncture (20 visits per calendar year)	20% after deductible	40% after deductible	Not covered
Lab and X-ray	20% after deductible	40% after deductible	30% after deductible
Inpatient Hospitalization	20% after deductible	40% after deductible	30% after deductible
Outpatient Surgery	20% after deductible	40% after deductible	30% after deductible
Urgent Care	20% after deductible	40% after deductible	30% after deductible
Emergency Room	20% after deductible (waived if admitted)		30% after deductible
Retail (30-day supply)			
Generic	$10 per refill		$10 per refill
Preferred	$30 per refill	40% up to $250	$30 per refill
Non-Preferred	$60 per refill		$30 per refill
Specialty Drug (30-day)	20% up to $100		$30 per refill
Mail Order (100-day supply)			
Generic	$20 per refill	NOT COVERED	$20 per refill
Preferred	$60 per refill		$60 per refill
Non-Preferred	$120 per refill		$30 per refill

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Medical

DIGITAL SELF CARE TOOLS

ANTHEM BLUE CROSS MEMBERS

Your emotional health is an important part of your overall health. With Emotional Well-being Resources, administered by Learn to Live, you can receive support to help you and your household live your happiest, healthiest lives.

Learn to Live has digital tools available anytime, anywhere that can help you identify thoughts and behavior patterns that affect your emotional well-being –and work through them. Learn effective ways to manage stress, depression, anxiety, substance use, and sleep issues.

Change your mind. Change your life™

Take a quick assessment to find the program that's right for you. To access Anthem's Emotional Well-being Resources:

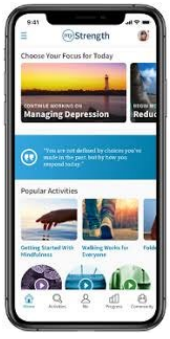
- Use the **Sydney Health app**
- Go to **My Health Dashboard**, choose **Programs**, and
- Select **Emotional Well-being Resources**

To download the Sydney Health app, go to Apple Store or Google Play.

KAISER PERMANENTE MEMBERS

Everyone needs support for total health — mind, body, and spirit. Digital tools can help you navigate life's challenges, make small changes that improve sleep, mood, and more, or simply support an overall sense of well-being.

The #1 app for meditation and sleep. Choose from hundreds of activities to build mental resilience, reduce stress, and experience better rest.



Evidence-based programs to help members set mental health goals, track progress, and get support managing depression, anxiety, and more.

1-on- emotional support coaching and self-care activities for many common challenges like anxiety, stress, and relationship issues. Adult members can use text-based coaching for 90 days per year.

For more information, visit kp.org/selfcareapps.

Medical

ALTERNATIVE OPTIONS TO ACCESS CARE

Get the care you need the way you want it. No matter which option you choose, your providers can see your health history, update your medical record, and give you personalized care that fits your life.

Choose where, when, and how you get care.

Call Kaiser Permanente anytime at 1-866-454-8855 (TTY 711) to make an appointment or to speak to an advice nurse.

24/7 care advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider.

In-person visit

Same-day appointments are often available. Sign on to kp.org anytime or call us to schedule a visit.

Email

Message your doctor's office with non-urgent questions anytime. Sign on to kp.org or use our mobile app.

Phone appointment

Save yourself a trip to the doctor's office for minor conditions or follow-up care.

Video visit

Meet face-to-face online with a doctor on your computer, smartphone, or tablet for minor conditions or follow-up care.

If you think you have a medical or psychiatric emergency, call 911 or go to the nearest hospital.

Need care now?

Know before you go.

Urgent care

An urgent care need is one that requires prompt medical attention, usually within 24 or 48 hours, but is not an emergency medical condition.

This can include minor injuries, backaches, earaches, sore throats, coughs, upper-respiratory symptoms, and frequent urination or a burning sensation when urinating.

Kaiser is available 24/7 to guide you. Call at 1-866-454-8855 (TTY 711).

Emergency care

A life-threatening injury or illness that requires care right away:

- Trouble breathing
- Severe chest pains
- Very bad injuries or wounds

TRAVELING? Kaiser members now have access to **Cigna's PPO Network** of providers and facilities. For more information, visit Kaiser's Care while traveling site where you can get more information on how to get care while traveling. You may also call Kaiser's Home Travel Line at (951) 268-3900 or visit kp.org/travel.

2024 Plan Rates

MEDICAL PLAN RATES

For Full-Time-All Employees (Except Employees Represented by the POA and IAFF, Local 230)

MEDICAL-Anthem $1500 Deductible Select HMO	Total Monthly Cost	Your Monthly Cost
Employee Only	$724.88	$0.00
Employee + Spouse	$1,594.78	$0.00
Employee + Children	$1,304.78	$0.00
Employee + Family	$2,247.18	$0.00

MEDICAL-Anthem $20 Copay Select HMO	Total Monthly Cost	Your Monthly Cost
Employee Only	$940.24	$94.02
Employee + Spouse	$2,068.48	$206.84
Employee + Children	$1,692.42	$169.24
Employee + Family	$2,914.64	$291.46

MEDICAL-Anthem $20 Copay Traditional HMO	Total Monthly Cost	Your Monthly Cost
Employee Only	$1,080.88	$345.52
Employee + Spouse	$2,377.90	$907.22
Employee + Children	$1,945.60	$658.76
Employee + Family	$3,350.68	$1,144.64

MEDICAL-Anthem $100 Deductible Select PPO	Total Monthly Cost	Your Monthly Cost
Employee Only	$2,684.40	$1,949.04
Employee + Spouse	$5,905.74	$4,435.06
Employee + Children	$4,831.96	$3,545.12
Employee + Family	$8,321.78	$6,115.74

MEDICAL-Anthem $100 Deductible Classic PPO	Total Monthly Cost	Your Monthly Cost
Employee Only	$2,871.06	$2,135.70
Employee + Spouse	$6,316.36	$4,845.68
Employee + Children	$5,167.88	$3,881.04
Employee + Family	$8,900.28	$6,694.24

MEDICAL-Anthem HSA $2500 Deductible Classic PPO	Total Monthly Cost	Your Monthly Cost
Employee Only	$1,653.72	$918.36
Employee + Spouse	$3,638.18	$2,167.50
Employee + Children	$2,976.70	$1,689.86
Employee + Family	$5,126.58	$2,920.54

2024 Plan Rates

MEDICAL PLAN RATES

For Full-Time-All Employees (Except Employees Represented by the POA and IAFF, Local 230)

MEDICAL-Kaiser HSA $3000 Deductible HMO	Total Monthly Cost	Your Monthly Cost
Employee Only	$596.84	$0.00
Employee + Spouse	$1,193.68	$0.00
Employee + Children	$1,044.46	$0.00
Employee + Family	$1,790.52	$0.00

MEDICAL-Kaiser $1500 Deductible HMO	Total Monthly Cost	Your Monthly Cost
Employee Only	$708.38	$0.00
Employee + Spouse	$1,416.74	$0.00
Employee + Children	$1,239.66	$0.00
Employee + Family	$2,125.12	$0.00

MEDICAL-Kaiser $25 Copay HMO	Total Monthly Cost	Your Monthly Cost
Employee Only	$865.12	$129.76
Employee + Spouse	$1,730.22	$259.54
Employee + Children	$1,513.94	$227.10
Employee + Family	$2,595.34	$389.30

2024 Plan Rates

MEDICAL PLAN RATES

For Full-Time-All Employees (Represented by the POA and IAFF, Local 230)

MEDICAL-Anthem $1500 Deductible Select HMO	Total Monthly Cost	Your Monthly Cost
Employee Only	$724.88	$0.00
Employee + Family	$1,956.12	$0.00

MEDICAL-Anthem $20 Copay Select HMO	Total Monthly Cost	Your Monthly Cost
Employee Only	$940.24	$94.02
Employee + Family	$2,537.14	$253.72

MEDICAL-Anthem $20 Copay Traditional HMO	Total Monthly Cost	Your Monthly Cost
Employee Only	$1,080.88	$328.96
Employee + Family	$2,916.70	$1,044.44

MEDICAL-Anthem HSA $2500 Deductible Classic PPO	Total Monthly Cost	Your Monthly Cost
Employee Only	$1,653.72	$901.80
Employee + Family	$4,462.58	$2,590.32

MEDICAL-Anthem $100 Deductible Classic PPO	Total Monthly Cost	Your Monthly Cost
Employee Only	$2,871.06	$2,119.14
Employee + Family	$7,747.56	$5,875.30

MEDICAL-Anthem $100 Deductible Select PPO	Total Monthly Cost	Your Monthly Cost
Employee Only	$2,684.40	$1,932.48
Employee + Family	$7,243.92	$5,371.66

MEDICAL-Kaiser HSA $3000 Deductible HMO	Total Monthly Cost	Your Monthly Cost
Employee Only	$596.84	$0.00
Employee + Family	$1,455.04	$0.00

MEDICAL-Kaiser $25 Copay HMO	Total Monthly Cost	Your Monthly Cost
Employee Only	$884.60	$132.68
Employee + Family	$2,202.66	$330.40

2024 Plan Rates

DENTAL PLAN RATES

For Full-Time-All Employees (Except Employees Represented by the POA and IAFF, Local 230)

DENTAL-Delta Dental HMO	Total Monthly Cost	Your Monthly Cost
Employee Only	$24.44	$0.00
Employee + Spouse	$48.86	$0.00
Employee + Children	$42.74	$0.00
Employee + Family	$73.30	$0.00

DENTAL-Delta Dental PPO	Total Monthly Cost	Your Monthly Cost
Employee Only	$50.88	$2.54
Employee + Spouse	$111.92	$5.60
Employee + Children	$122.12	$6.10
Employee + Family	$157.72	$7.88

For Full-Time-All Employees (Represented by the POA and IAFF, Local 230)

DENTAL-Delta Dental HMO	Total Monthly Cost	Your Monthly Cost
IAFF & POA employees	$41.82	$0.00

DENTAL-Delta Dental PPO	Total Monthly Cost	Your Monthly Cost
IAFF & POA employees	$105.90	$5.30

2024 Plan Rates

VISION PLAN RATES

For Full-Time-All Employees (Represented by MEF,CAMP,ALP AEA, AMSP,UNIT 99)

VSP SIGNATURE	Total Monthly Cost	Your Monthly Cost
Employee Only	$6.98	$0.00
Employee + Spouse	$9.96	$0.00
Employee + Children	$12.30	$0.00
Employee + Family	$19.68	$3.68

VSP-CHOICE	Total Monthly Cost	Your Monthly Cost
Employee Only	$7.34	$0.00
Employee + Spouse	$10.48	$0.00
Employee + Children	$12.96	$0.00
Employee + Family	$20.72	$4.72

For Full-Time-All Employees (Represented by ABMEI, IAFF, IBEW, OE3, & POA)

VSP SIGNATURE	Total Monthly Cost	Your Monthly Cost
Employee Only	$11.46	$11.46
Employee + 1 Dependent	$16.32	$16.32
Employee + 2 or more Dependents	$29.24	$29.24

VSP-CHOICE	Total Monthly Cost	Your Monthly Cost
Employee Only	$12.04	$12.04
Employee + 1 Dependent	$17.18	$17.18
Employee + 2 or more Dependents	$30.80	$30.80

Getting Care When You Need It Now

TYPE	APPROPRIATE FOR	EXAMPLES	ACCESS & CONTACT INFO
Nurseline 	Quick answers from a trained nurse	• Identifying symptoms • Decide if immediate care is needed • Home treatment options and advice	24/7 **Anthem Blue Cross:** (800) 977-0027 **Kaiser:** (800) 464-4000
Online visit 	Minor illnesses and conditions	• Common cold, flu, fever • Headache, migraine • Skin conditions • Allergies	24/7 **Anthem Blue Cross:** livehealthonline.com **Kaiser:** www.kp.org
Office visit 	Routine medical care and overall health management	• Preventive care • Illnesses, injuries • Managing existing conditions	Office Hours **To locate a provider:** • Anthem PPO • Anthem HMO • Kaiser Permanente
Urgent care, Walk-in clinic 	Non-life-threatening conditions requiring prompt attention	• Stitches • Sprains • Animal bites • Ear-nose-throat infections	Vary, up to 24/7 **To locate a facility:** • Anthem PPO • Anthem HMO • Kaiser Permanente
Emergency room 	Life-threatening conditions requiring immediate medical expertise	• Suspected heart attack or stroke • Major bone breaks • Excessive bleeding • Severe pain • Difficulty breathing	24/7 **To locate a facility:** • Anthem PPO • Anthem HMO • Kaiser Permanente

Getting Care When You Need It Now

TELE-HEALTH

Now you can get the health care you need without all the hassle.

With LiveHealth Online, you don't have to schedule an appointment, drive to a provider's office, and then wait for your appointment. You don't even have to leave your home or office. Healthcare providers can answer questions, make a diagnosis, and even prescribe basic medications when needed. All online visits U.S. board-certified doctors, psychiatrists or licensed therapists are private, secure and convenient.

	LiveHealth Online Medical	LiveHealth Online Psychology	LiveHealth Online Psychiatry
Type of service	Whenever you have a health concern and don't want to wait.	If you're feeling stressed, worried or having a tough time & you need to speak with a licensed therapist.	If you are coping with a common behavioral health condition psychiatrists are available to provide an evaluation and medication management.
Conditions addressed	Cold and flu symptoms such as a cough, fever and headaches, allergies, sinus infections or family health questions.	Stress, anxiety, depression, relationship or family issues, grief, panic attacks or stress from coping with a sickness.	Anxiety, stress, depressions, bipolar disorder, obsessive compulsive disorder or post-traumatic stress disorder.
How soon can you meet with a provider?	Doctors are available 24/7, 365 days.	Appointments within 4 days.	Appointments within 14 days.
How to get started	• Enroll for free at www.livehealthonline.com. • Download their mobile app then sign up or log in. • You're ready to see a doctor.	For your first visit, set up a time by: • **Online:** Visit www.livehealthonline.com and sign up or log in. Select LiveHealth Online Psychology. • **Mobile app:** Download mobile app and then sign up or log in. Choose LiveHealth Online Psychology. • **Phone:** Call 1-844-784-8409 from 7 a.m. to 11 p.m. ET or PT.	To schedule an appointment, all you have to do is: • Just visit www.livehealthonline.com or • Call 1-888-548-3432.
Cost[1]	$0 copay	$0 copay	$0 copay

[1]For those enrolled in High Deductible Health Plans, $0 copay applies once deductible is met.

Download on the App Store | GET IT ON Google Play

These services are for non-emergency health issues only.
If you are experiencing life threatening emergency, please call 911.

Health Savings Account

A Health Savings Account (HSA) is a special "tax advantaged" account owned by an individual that is used in conjunction with a High Deductible Health Plan (HDHP).

This account comes with a debit card that you can use to pay for qualified medical expenses. For a detailed list of qualified medical expenses and further information, please refer to the plan documents.

In 2024, you can contribute a maximum of $4,150 for employee only or $8,300 for employee + one or more. This maximum includes both employer and employee contributions.

Since your medical expenses may change within the year, you may change (increase or decrease) your contributions at any time.

This money helps pay for qualified medical expenses.

If you have remaining funds at the end of the year, they will roll over into next year, there is no "use it or lose it" rule.

These funds can also earn interest, or you can choose to invest the funds using the online investment tool. (Plan minimums may apply)

If you decide you do not want to continue to be enrolled in the HDHP plan, this account stays with you.

You may only contribute to the account if you are enrolled in a HDHP plan.

You may not continue to contribute to an HSA account once you are enrolled in Medicare. When you turn 65, you can use any unused funds in the account for any purpose, penalty free, but you will be subject to ordinary income tax.

If you elect of enroll in one of the HDHP plans offered through Kaiser or Anthem for 2024, you are not eligible to enroll in the City's Flexible Spending Medical Reimbursement Account (MRA).

Dental

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

City of San José lets you choose between two dental plans from Delta Dental. Either way, you'll get reliable dentist networks and affordable preventive care.

Your options are:

DELTA DENTAL®

PPO Plan

- This preferred provider plan offers the convenience and flexibility of visiting any licensed dentist, anywhere.
- Covered services are paid based on a percentage — if, for example, fillings are covered at 80%, you pay the remaining 20%.
- Get the most plan value by choosing a Delta Dental PPO dentist. PPO network dentists complete claim forms for you and can help advise you on questions regarding your share of the payment.

DeltaCare® USA

Dental HMO

- Under this HMO-type plan, you'll have your choice of skilled primary care dentists from the DeltaCare USA network.
- Select a primary care dentist, who will then coordinate any needed referrals to a specialist.
- Covered services provided by your DeltaCare USA dentist have preset copayments (dollar amounts), which are listed in your plan booklet.
- There are no maximums or deductibles.

Dental

PLAN COMPARISON

	Delta Dental PPO	DeltaCare USA
Can I go to any dentist?	You can visit any licensed dentist to receive coverage, but you'll save the most at an in-network dentist.	You must select a DeltaCare USA primary care dentist and visit this dentist to receive benefits.
What procedures are covered?	Your plan covers a wide range of services, with no exclusions for most pre-existing conditions. Preventive care, like routine cleanings and exams, is offered at no cost.	Your plan covers over 300 procedures, with no exclusions for most pre-existing conditions. Preventive care, like routine cleanings and exams, has no copayments.
Are there deductibles and maximums?	No deductible however Delta Dental will only pay up to $2,100 per calendar year.	No, there are no annual deductibles or maximums.
Am I covered for treatment I began under a different employer-sponsored dental plan?	Coverage is provided only for treatment started and completed after your effective date. Orthodontic treatment may be an exception to this rule.	Coverage is provided only for treatment started and completed after your effective date. Orthodontic treatment may be an exception to this rule.
What if I started orthodontic treatment under my previous dental plan?	Typically, Delta Dental pays the remaining benefit not paid by your prior dental plan.	You are responsible for the copayments and fees subject to the provisions of your prior dental plan.
What happens if I need to see a specialist?	You do not need a referral from your dentist.	Contact your DeltaCare USA primary care dentist to coordinate your referral.
What is my out-of-area coverage?	You can visit any licensed dentist.	You have a limited benefit to go out of network for emergency care.
How do I change my dentist?	You can change your dentist at any time without contacting Delta Dental.	You can change your selected or assigned primary care dentist online or by telephone.
Do you need to fill out claims?	If you visit a Delta Dental dentist, the dental office will file the claim for you. If you go to a non–Delta Dental dentist, you may have to submit the claim yourself.	There are generally no claim forms under your plan.

Dental

Dental PPO

	In-Network	Out-Of-Network[1]
Calendar Year Deductible	$0 per individual $0 per family	$0 per individual $0 per family
Annual Plan Maximum per Calendar Year	$2,100 per individual	$2,000 per individual
Waiting Period	None	None
Diagnostic and Preventive Exams, 2 cleanings & x-rays	Plan pays 100%	Plan pays 85%
Basic Services Fillings, simple tooth extractions and sealants	Plan pays 85%	Plan pays 85%
Endodontics (root canals)	Plan pays 85%	Plan pays 85%
Periodontics (gum treatments)	Plan pays 85%	Plan pays 85%
Oral Surgery	Plan pays 85%	Plan pays 85%
Major Services Crowns, inlays, onlays, and cast restorations	Plan pays 85%	Plan pays 85%
Prosthodontics Bridges and dentures	Plan pays 65%	Plan pays 60%
Orthodontic Services Orthodontia Lifetime Maximum	(Adults and dependent children up to **age 24**) Plan pays 60% $2,000	

1 Out of network dentists may directly bill the patient for the difference between Delta Dental's payment and their actual charge for services (balance billing).

For dental services amounting to at least $300, it is suggested that you ask your provider's office to request a pre-determination estimate from Delta Dental. This ensures that your procedure is covered and helps you plan your payment in advance.

Dental

	DeltaCare USA Dental HMO In-Network
Diagnostic & Preventive	
Office Visit	No Cost
Teeth Cleaning – 1 per 6 months	
X-rays	
Sealants – per tooth	
Restorative	
Amalgam filling – 1-3 surfaces	$0
Composite filling – 1-3 surfaces	$25-$55
Periodontics	
Scaling and root planning – per quad	No Cost
Gingivectomy	
Osseus Surgery	
Endodontics	
Pulp Cap	No Cost
Therapeutic Pulpotomy	
Root Canal Therapy	
Prosthodontics	
Immediate – Upper or lower	No Cost
Complete – Upper or lower	
Partial denture – Upper or lower	
Crown and Bridge	
Inlay/onlay	No Cost
Crown – Porcelain/ceramic substrate	$175
Crown – Porcelain fused with high noble metal	$175
Crown – Full cast high noble metal	$175
Oral Surgery	
Extractions – Impacted tooth: soft tissue	No Cost
Extractions – Impacted tooth: partial bony	
Extractions – Impacted tooth: full bony	
Orthodontic Services	
Adult	$1,000
Dependent Child (up to **age 24**)	$1,000

Dental

MEMBER EXCLUSIVE DISCOUNTS

While your oral health remains the top priority, Delta Dental also care about the bigger picture — your overall well-being. That's why dental members will have access to preferred pricing on hearing aid and LASIK services through Amplifon Hearing Health Care and QualSight. Great discounts for brand oral care are also available with BrushSmart™.

- Discounts on hearing aids and one year of free follow-up care
- 66% average savings off retail hearing aid pricing
- Visit amplifonusa.com/deltadentalins or call Amplifon at **888-779-1429** for more information

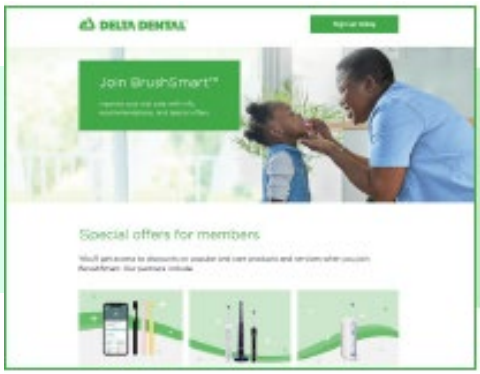
- Discount on LASIK eye surgery, including pre- and post-operative visits
- 30% off national average price
- Over 900 LASIK locations nationwide with experienced LASIK surgeons
- For more information, visit qualisight.com/-delta-dental or call QualSight at 855-248-2020

BrushSmart™ transforms your oral health

Sign up today for special offers on popular oral health care brands.

BrushSmart™ is a free oral wellness program designed to improve your oral care at home. When you sign up, you will also get special offers on dental products and incentives for maintaining a healthy smile.

Delta Dental has partnered with great dental brands like Oral-B, Philips Sonicare, and Quip to bring members deals and products tailored to members' specific needs and lifestyle.



Join at brushsmart.org.

Fill out the online form to get immediate access to exclusive BrushSmart offers.

Vision

Routine vision exams can not only correct vision, but also detect more serious health conditions. We give you a choice between two vision plans through Vision Service Plan.

	VSP Signature	VSP Choice
Exam and glasses copay	$10	$10
Frames	$150 allowance $170 allowance for featured frames $80 Costco, Walmart and Sam's Club frame allowance	$150 allowance $170 allowance for featured frames $80 Costco, Walmart and Sam's Club frame allowance
Lenses		
Single Vision Lenses	Covered in Full	Covered in Full
Lined Bifocal Lenses	Covered in Full	Covered in Full
Lined trifocal Lenses	Covered in Full	Covered in Full
Lens Options	Covered in Full (dependent children only)	
Polycarbonate		Covered in Full
Standard Progressive Lenses	Covered in Full	Covered in Full
Premium Progressive Lenses	$80 - $90	$95- $105
Custom Progressive Lenses	$120 - $160	$150 - $175
Contact Lens (in lieu of glasses)		
Elective	$105 Allowance	$105 Allowance
Medically Necessary	Covered in Full	Covered in Full
Retinal Screening	$35	N/A
Frequency		
Exam	12 months	12 months
Lenses	12 months	12 months
Contact Lenses	12 months	12 months
Frames	24 months	12 months

Vision

EXCLUSIVE MEMBER DISCOUNTS

Essential Medical Eye Care

- Fully covered retinal screening for members with diabetes.
- These high-resolution images of the inside of the eye are a non-invasive way to monitor diabetes.
- Exams and services to treat immediate issues like pink eye and sudden changes in vision.
- Treatment options to monitor ongoing health conditions such as dry eye, diabetic eye disease, glaucoma, and more.

Extra Savings on Glasses & Sunglasses

- Extra $20 to spend on featured frame brands. Go to vsp.com/special offers for details.
- 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam, or get 20% from any VSP provider within 12 months of your last WellVision Exam.

Retinal Screening

- No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam

Laser VisionCare℠ Program

- Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.
- VSP members will not pay more that $1,500 per eye for PRK, $1,800 per eye for LASIK, and $2,300 per eye for custom LASIK, Custom PRK, or Bladeless LASIK.
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

TruHearing Hearing Aid Discount

VSP® Vision Care members can save up to 60% on a pair of hearing aids with TruHearing. Your dependents and extended family members are eligible as well.

TruHearing also provides members with:

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

For more information on VSP's Exclusive Member Extras, visit vsp.com/offers.

Life 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.

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, hearing, or if you die in an accident. The cost of Basic Life Insurance is paid in full by the City of San José. Coverage is provided by The Standard.

CITY PAID LIFE AND AD&D

Class 1 – Management	2 times your Annual Earnings, subject to a maximum of $750,000.
Class 2- Non-Management	
Unit 1 (Police)	$10,000
Unit 2 (Fire)	$10,000
Unit 3 (Bldg, Mechanic and Electric Inspectors (IBMEI)	$20,000
Unit 4 (MEF)	$20,000
Unit 5 (Operating Engineers/ Local #3) (OE3)	$20,000
Unit 6 (Electrical Workers) (IBEW)	$20,000
Unit 7 (Unrepresented)	$20,000
Unit 8 (Confidential) (CEO)	$20,000
* Note: The above units may change as defined by CSJ, as unions get added or deleted.	
San José Sports Authority Members	$10,000
San José Arena Authority Members	$10,000

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

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

Life Insurance

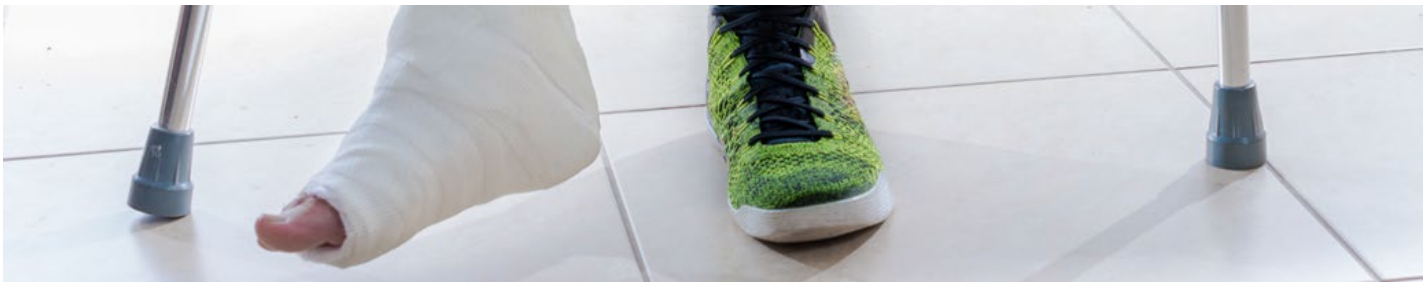
VOLUNTARY LIFE AND AD&D

As an eligible employee, the City of San José allows you to apply for additional life coverage for you and your family.

Evidence of insurability is required in certain circumstances and is waived at certain times.

Employee	Increments of $10,000 up to $750,000 (not to exceed an amount equal to 6 times your annual earnings, rounded to the next multiple of $10,000 if not already a multiple of $10,000).
Spouse/Domestic Partner	Increments of $10,000 to a maximum of $250,000, but not to exceed 100% of your combined Basic & Additional Life coverage amount. Note: Matching AD&D insurance is included.
Children	$5,000 or $10,000 for child coverage, not to exceed 100 percent of your combined Basic & Additional Life coverage amount. Note: No AD&D Insurance.

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

Voluntary long-term disability (LTD) insurance is provided through the City's group policy with The Standard.

Employees should note that the **City does not contribute to State Disability Insurance (SDI).** City of San José employees are not covered under California State Disability Insurance programs. The City's Voluntary LTD insurance policy covers employees for up to two thirds of their pre-disability earnings if they become unable to work due to work or non-work-related disabilities. This coverage is in lieu of SDI and is 100% employee paid.

Individuals may select between two plans. The two plans provide identical benefits, with the following exceptions:

- **LTD-30 Plan**: If an individual elects coverage under the LTD-30 Plan and becomes disabled, benefits begin after 30 days of continuous disability. There is no preexisting condition exclusion under this plan, and there is no requirement to participate in a rehabilitation plan.
- **LTD-60 Plan:** If an individual elects coverage under the LTD-60 Plan and becomes disabled, benefits begin after 60 days of continuous disability. The individual will be subject to a preexisting condition exclusion under this plan and may be required to participate in a rehabilitation plan if able to do so.

Monthly Benefit Amount	Plan pays 66% of the first $15,000 of your pre-disability earnings; 40% of the next $12,500 of your pre-disability earnings	
Maximum Monthly Benefit	$15,000	
Benefits Begin After:	LTD-60	LTD-30
Accident	60 days of disability	30 days of disability
Sickness	60 days of disability	30 days of disability
Maximum Payment Period*	Age 65	

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

Travel Assistance

ADMINISTERED BY THE STANDARD

Things can happen on the road. Passports get stolen or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Travel Assistance can help you navigate these issues and more at any time of the day or night.[1]

You and your spouse are covered with Travel Assistance — and so are kids through age 25 — with your group insurance from Standard Insurance Company (The Standard).[2]

assist america®

800.872.1414
United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda

Everywhere else: **+1.609.986.1234**

Text: **+1.609.334.0807**

Email: medservices@assistamerica.com

SECURITY THAT TRAVELS WITH YOU

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

- Visa, weather and currency exchange information, health inoculation recommendations, country-specific details and security and travel advisories
- Credit card and passport replacement and missing baggage and emergency cash coordination
- Help replacing prescription medication or lost corrective lenses and advancing funds for hospital admission
- Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains[3]
- Connection to medical care providers, interpreter services, local attorneys and assistance in coordinating a bail bond
- Return travel companion if travel is disrupted due to emergency transportation services or care of minor children if left unattended due to prolonged hospitalization
- Assistance with the return of your personal vehicle if your emergency transportation services leave it stranded
- Evacuation arrangements in the event of a natural disaster, political unrest and social instability

Get the App

Get the most out of Travel Assistance with the Assist America Mobile App.

Click one of the links below or scan the QR code to download the app. Enter your reference number and name to set up your account. From there, you can use valuable travel resources including:

- One-touch access to Assist America's Emergency Operations Center
- Worldwide travel alerts
- Mobile ID card

Reference Number:
01-AA-STD-5201
Embassy locator

Download on the App Store | GET IT ON Google Play

Standard Insurance Company | 1100 SW Sixth Avenue, Portland, OR 97204 | standard.com

[1] Travel Assistance is provided through an arrangement with Assist America, Inc. and is not affiliated with The Standard. Travel Assistance is subject to the terms and conditions, including exclusions and limitations of the Travel Assistance Program Description. Assist America, Inc. is solely responsible for providing and administering the included service. Travel Assistance is not an insurance product. This service is only available while insured under The Standard's group policy.

[2] Spouses and children traveling on business for their employers are not eligible to access these services during those trips.

[3] Must be arranged by Assist America, Inc.

Flexible Spending Account (FSA)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend., and reimbursements from your FSA accounts are tax-free. The catch is that you have to use the money in your account by our plan year's end. Otherwise, that money is lost, so plan carefully. You must re-enroll in this program each year. P&A Group administers this program.

IMPORTANT CONSIDERATIONS

- There's no "crossover" spending allowed between the healthcare and dependent care accounts.
- Expenses must be incurred between 01/01/2024 and 03/15/2025 and submitted no later than 06/15/2025.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- Unused amounts will be lost at the end of the grace period (June 15 of the following year), so it is very important that you plan carefully before making your election.
- FSA funds can be used for eligible expense incurred by you, your spouse, and your tax dependents only. Your spouse or tax dependent children do not have to be covered on the City of San José health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).
- Keep your receipts as proof that your expenses were eligible for IRS purposes.

ELIGIBLE EXPENSES

Eligible expenses include medical, dental, and vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents.

You may access your entire Medical Reimbursement Account (MRA) annual election from the first day of the plan year and you can set aside up to $3,050 per year. If you are enrolled in the Anthem or Kaiser HSA Qualified Health Plan, you cannot participate in the MRA FSA.

Some of the FSA eligible expenses are:

- Acupuncture
- Braces
- Chiropractors
- Copays
- Condoms
- Contact lens and eyeglasses
- Deductibles for medical coverage
- Guide dog/service animal
- Hearing devices & batteries
- Medical alert bracelets
- Orthotics
- Prosthesis
- Prenatal vitamins

Some FSA eligible expenses may require Prescription or Letter of Medical Necessity. For a more extensive list please refer to IRS Publication 502 or visit www.padmin.com.

Flexible Spending Account (FSA)

DEPENDENT CARE FSA

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

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

Eligible Dependents Include:

- Children under the age of 13 who qualify as dependents on your federal tax return; and
- Children or other dependents of any age who are physically or mentally unable to care for themselves and who qualify as dependents on your federal tax return

COMMUTER PLAN

In 1984, the IRS decided to give hard-working employees, tax-free benefits for commuting to work via public transportation since most employers offered free parking. Today's benefits, IRS Section 132(f), have been expanded to include parking, vanpools and even biking as parking costs in most cities are at a premium, and transit ridership fees are on the rise.

Pay for qualified parking, transit and vanpooling expenses using money you've set aside pre-taxes. Paying with pre-tax dollars allows you to save on transit passes, tokens, fare cards, vouchers, etc., when riding on mass transit, or when riding with someone in the business of transporting people for hire (it must be in a vehicle that seats six or more adults, excluding the driver).

For 2024, you can set aside $315 for transit expenses and $315 for parking*.

Some eligible expenses are:

- Bus or ferry
- Parking at or near public transportation to get to work
- Parking near or near work
- Streetcar or vanpool
- Subway or train

Tools or gas expenses are NOT eligible for reimbursements.

*For 2024, federal tax rules allow up to $315 per month in pre-tax transportation benefits. The market value of the City provided Smart Pass of $90 per month is allocated towards the limit of $315 per month. Therefore, the maximum employees may contribute for 2024 towards the Pre-Tax Commuter Benefit is $225 per month.

Employee Assistance Program

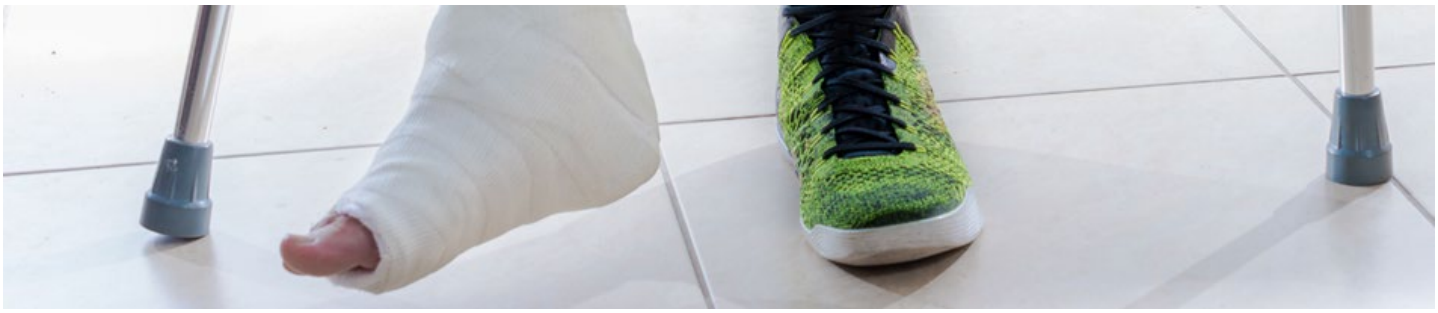
There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through Concern can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources. Best of all, it's free for all employees and their eligible family members.

Short-term counseling are available, depending on the type of help you need. The program allows you and your family/household members confidential counseling with experienced licensed counselors. Additional benefits are available through your medical plan.

Counseling Sessions **Non-Sworn**	Counseling either via face-to-face, video , telephonic, or text/chat. **8** sessions per issue type per member.
Counseling Sessions **Sworn**	Counseling either via face-to-face, video, telephonic, or text/chat **20** sessions per issue type per member. A specialty panel of counselors is available. Specialty panel counselor are familiar to the particular situations a First Responder may face while on the job. Click here for the First Responder specific panel of counselors.
Counseling Sessions **Part-time Unbenefited Employees**	Effective January 1, 2024, part-time unbenefited employees in the Municipal Employees' Federation (MEF) Union can access employee assistance program services including 5 counseling sessions per issue type per 12-month period through face-to-face, video, telephonic, or text/chat options. Please note that this benefit is not available for dependents of part-time unbenefited employees in MEF.
Financial Consultation	Certified financial experts and fraud resolution specialists provide two free30-minute consultations on financial topics ranging from money management to identity theft response.
Adult Family Care	Wide array of resources to help care for an elderly or disabled relative. Services include confidential support, education, and referrals to local and national services.
Parent & Childcare	Wide array of resources that help parents raise smart, healthy, and well- rounded children. Services include new care baby kit, childcare resources & referrals, programs for children with special needs, academic services, summer care options or tutors, mentors and enrichment programs.
Online Sources	Concern Digital Platform, Online Therapy with BetterHelp, Resilience Hub™, Mental Wellness Resource Center, and Life Adviser. **eMLife** Concern has partnered with **eMindful** to provide access to an entire suite of evidenced-based live and on-demand mindfulness solutions. To log-in, visit https://app.concernhealth.com/sso/emindful and log-in with company code **SanJose.**

Consultants are available to assist you 24/7, 365 days a year.
You may speak with an intake consultant at (800) 344-4222 or you may visit
employees.concernhealth.com
Company Codes: **sanjose**

Personal Accident Insurance



ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

GROUP #: OK10280

The City of San José offers voluntary Personal Accident Insurance is available through the City's group policy with New York Life (formerly Cigna). The insurance is 100% employee paid and can help protect families from financial hardship by paying a specified benefit amount upon death or serious injury due to a covered accident.

Cigna accident insurance benefits include:

Additional benefits include, but are not limited to, rehabilitation, hospital stays, bereavement and trauma counseling, spouse job training, childcare and identity theft protection.

Coverage is available for dependent spouses and children.

Filling critical gaps in coverage and unexpected expenses not covered by other insurance benefits, such as life, disability, health, or workers' compensation.

Guaranteed issue coverage - no medical underwriting is required.

Payable benefits for living events such as dismemberment, paralysis, and coma.

Protection against accidents anywhere in the world, on or off the job, on business, on vacation, and at home.

Please note: Illnesses are **not** covered.

WHO IS ELIGIBLE FOR COVERAGE?

You – You are eligible for coverage if you are a full-time or part- time benefited employee on active service at your customary place of employment who works for the Policyholder, including mayor or city council member or contract employee of a mayor or city council member, or a participating retiree.

Your Family – You may elect to cover your lawful spouse/domestics partner and dependent coverage up to the age of 26, with no restrictions based on full-time student or marital status. Please be aware that, in the event of disability, coverage will conclude at age 26.

No one may be covered more than once under this plan. If covered as a retiree, you cannot also be covered as a dependent.

Personal Accident Insurance

YOUR MONTHLY COST

Your cost will depend on the benefit amount and coverage option you select from the chart below.

Your Benefit Amount	Monthly Cost for You and Your Family	Monthly Cost for You Only
$10,000	$.35	$.25
$20,000	.70	.50
$30,000	1.05	.75
$40,000	1.40	1.00
$50,000	1.75	1.25
$60,000	2.10	1.50
$70,000	2.45	1.75
$80,000	2.80	2.00
$90,000	3.15	2.25
$100,000	3.50	2.50
$120,000	4.20	3.00
$150,000	5.25	3.75
$200,000	7.00	5.00
$250,000	8.75	6.25
$300,000	10.50	7.50
$400,000	14.00	10.00
$500,000	17.50	12.50

Costs are subject to change. Benefit amounts over $250,000 cannot be greater than 10 times your annual earnings. Benefit amounts cannot exceed $300,000 for your spouse and $100,000 for each child.

Please note that premiums are calculated based on the following rates per $1,000 of coverage: $.025 for employee only and $.035 for employee and family. Actual premiums will be calculated to the nearest cent as shown above.

Wellness

Wellness is a way of living-eating a healthful diet, being physically active and managing one's well-being. The everyday choices we make can help us live healthier, happier, and more fulfilling lives—both at work and at home. Studies show workplace wellness programs reduce health-care costs, reduce absenteeism and turnover, and improve employee health and well-being.

Implemented in 2016 by the Benefits Division, the current City of San José Wellness Rewards Program requires employees to complete simple health screenings each calendar year from January 1st through October 31st. There are two rewards programs, Basic and Enhanced. Employees can earn $35 by participating in the Wellness Basic Program by completing these easy steps:

- Choose your Primary Care Physician (PCP) and Dentist.
- Get your Annual preventative physical, dental and vision checkups, and biometrics.
- Manage your cholesterol levels, weight, blood pressure, and Glucose.

Employees can earn an additional $15 by participating in Wellness Enhanced Program and completing all steps of the Wellness Basic Program with the addition of using an alternative mode of transportation to get to work at least once before October 31st of each calendar year. For 2024 working remotely will count as an alternative mode of transportation. To be eligible for the program employees must be either full-time or part-time benefited and enrolled in a CSJ sponsored medical plan. Employees enrolled in health-in-lieu are not eligible to participate; unless they are covered as a dependent of another CSJ employee.

Each year employees who wish to continue enrollment in the program must re-enroll during each Open Enrollment. Employees who do not enroll as a new hire or do not enroll during Open Enrollment can enroll in the program by completing the Wellness Rewards Program Enrollment form anytime from January 1st through September 30th. Rewards are paid out each year in Pay Period 25 and the rewards are subject to tax withholdings.

For more information on Wellness visit the City of San José Wellness SharePoint site by clicking here (you will need to be logged into SharePoint to view this page).

Financial/Retirement

DEFERRED COMPENSATION PLAN

The City of San José 457(b) Deferred Compensation Plan was established under Section 457 of the IRS Code. It is a voluntary benefit that provides a convenient way for City employees to defer and invest a portion of their wages into a retirement account.

Participants are eligible to contribute pre-tax and/or Roth (after tax) money directly from their paycheck up to limits set by the IRS. Employees can choose to contribute to both options which will provide distribution choices at retirement. Assets in the participants' account accumulate tax deferred until the participant initiates a roll-over, distribution, or required minimum distribution commences. Assets in the participants' account are made available for distribution upon a qualifying event taking place. Qualifying events are defined as retirement, separation from service, death, or an unforeseeable financial hardship. The complete text of the Deferred Compensation Plan can be found in Chapter 3.48 of the San José Municipal Code.

Plan Options

Pre-Tax

Contributions and earnings on the investment in this plan are not subject to current federal or state income taxes. Taxes become payable when deferred income plus earnings are distributed, presumably during retirement when you are in a lower income tax bracket.

Roth Post-Tax

Contributions to this plan are considered "after-tax," which means taxes are withheld when you contribute. However, qualified distributions on your contributions plus any earnings are completely tax-free. Earnings and contributions can be withdrawn tax-free as long as certain conditions are met (separation from service, age 59 ½ and invested at least 5 years) Presumably, employees may be in a higher tax bracket at the time of their retirement or separation from employment and pay less in taxes at that time.

Financial/Retirement

Enrollment in the Plan

Employees may enroll at any time during their employment with the City. Enrollment options are as follows:

- As a New Hire, you will have the opportunity to elect enrollment via the eWay onboarding activity guide. That remains an option for 60 days past your hire date.
- Enroll by completing the EZ Enrollment Form located on the City's website: https://www.sanjoseca.gov/home/showpublisheddocument/39986/637940896930100000.
- Enroll online. Employees can access the plan site and complete the enrollment process at https://sanjosé.beready2retire.com/.

Maximum/Minimum Amount of Deferral

Under federal law, there is a maximum amount that may be deferred in a calendar year as set forth by the IRS. Contributions can be 100% of gross compensation or a dollar limit not to exceed the contribution in effect for the current year. The minimum amount that may be deferred is $25 per pay period. For maximum limits for the current calendar year, refer to the annual contribution limits on the City's Deferred Compensation webpage at: https://sanjosé.beready2retire.com/.

How to Make Deferred Compensation Contribution Changes

Participants can make contribution changes online or by phone:

Online: https://sanjosé.beready2retire.com/ Instructions for making online contribution changes can be accessed on the City's website.
Phone: (800) 584-6001
Paycheck deductions for deferred compensation will begin within 1-2 pay periods following the change.

Investment of Deferred Wages

The Deferred Compensation Advisory Committee (DCAC) oversees the program and has the authority to make decisions on behalf of the City as to the investment policy and the choice and nature of investments to be available under the Plan. The DCAC and its independent advisor determine the investment vehicles offered in the plan. Participants have control over how and where their money is invested and can move the investment dollars between funds of various returns and risk. Participants' deferred income is placed in an account established for them with the plan administrator. All payroll deductions and interest earnings are credited to the account. All assets are held by the City in a trust for the exclusive benefit of the participants and beneficiaries of the Plan. Participants have 30 investment options to invest their deferred assets. Participants may transfer their money between investment options at any time. For more information, visit http://sanjose.beready2retire.com/ or call (408) 535-1285.

Financial/Retirement

Catch-Up Provisions

The IRS has Special Catch-Up Provisions that allows participants to exceed the current designated annual maximum. These include:

- 3-Year Catch-Up Provision: allows participants to exceed the current designated annual maximum during the three (3) years prior to the year designated as the employee's normal retirement age in order to make up for years when they did not invest the maximum amount for which they were eligible if certain requirements are met.
- Catch-Up Provision for Participants 50 Years or Older: allows participants who are age 50 or older, or who will turn age 50 in the calendar year, to contribute an additional amount to the established annual maximum contribution limit.
- Military Service Provision: The Uniformed Service Employment and Re-employment Act of 1994 (USERRA) allows members of the uniformed service to deposit missed contributions into their Deferred Compensation Account due to military service if certain requirements are met.

Contact the deferred compensation service provider at (877) 464-4748 or email HRBenefits@sanjoséca.gov for additional information regarding the Catch-up Provisions.

Loan Provision

The Plan provides flexibility through loan options for active employees. Participants can borrow money from their pre-tax Deferred Compensation account. There are 2 types of loan:

- General Purpose loans can be used for any reason and have a maximum repayment period of five (5) years.
- Residential loans must be used for the purchase or renovation of a primary residence and have a maximum repayment period of 20 years.

The Plan's loan program allows for a maximum of one (1) of each type of loan to be outstanding at any one (1) time. The minimum loan amount is $1,000 and the maximum loan amount is 50% of the participant's account value or $50,000, whichever is less. Loan information can be obtained by contacting the deferred compensation service provider's customer service center at (800) 584-6001.

Beneficiary Designations

Beneficiary designations on deferred compensation accounts should be reviewed after any major life change. If the participant is married and his/her spouse was not named as the beneficiary, the spouse may have community property rights to the account funds unless the spouse signs an acknowledgement that he or she is not a beneficiary. Participants are encouraged to immediately provide their beneficiary information to the deferred compensation service provider as soon as possible. Participants can add or change their beneficiaries by accessing their deferred compensation account online at https://sanjosé.beready2retire.com/ or by calling the deferred compensation service provider's customer service center at (800) 584-6001.

Financial/Retirement

VOLUNTARY EMPLOYEE BENEFICIARY ASSOCIATION (VEBA) PLAN

A VEBA is a defined contribution health reimbursement arrangement plan for retiree healthcare expenses such as post-retirement healthcare premiums, prescriptions, co-pays, and other qualified healthcare related expenses. The complete text of the VEBA Plans can be found in Chapter 3.57 (Sworn) and 3.58 (Federated) of the San José Municipal Code.

Plan Details

While employed with the City of San José, eligible employees will make mandatory ongoing contributions into the VEBA on a pre-tax basis. Beginning Pay Period 8 2018 (March 25, 2018 - April 7, 2018), Tier 2B and Police and Fire Tier 2 employees* are mandated to contribute to the VEBA as show below:

Employee Unit	VEBA Contribution Rate
Police/Fire	4.0%
Federated	2.0%

* Please note that CalPERS Classic employees in the Federated System hired after September 27, 2013, sworn Police employees hired after August 4, 2013, and sworn Fire employees hired after January 2, 2015, are also mandated to join the VEBA. Those members who were eligible and chose to opt-into VEBA and opt-out of retiree healthcare have alternate contribution requirements.

Management of Your Account

One of the benefits of a VEBA plan is your ability to manage your account throughout the course of your employment with the City. Management of your account allows you to determine your investment allocations and to ensure that your contact information and eligible dependent information is up to date. Prior to your separation from service with the City, you can monitor your account and to allocate your investments.

Accessing Funds

Reimbursements for eligible medical expenses after retirement are also tax-free. The VEBA account reimburses eligible medical expenses for individuals who have either

- terminated City service and have reached the required retirement age based on their retirement system OR
- retired for service, service-connected disability, or nonservice connected disability

If an employee becomes a member of a reciprocal retirement system, the VEBA funds can be accessed after retirement from that system. The VEBA reimburses qualified out-of-pocket healthcare costs (including but not limited to health, dental, and vision insurance premiums, copays and deductibles, prescription costs, Medicare Parts B & D premiums, Medicare supplement insurance premiums, and qualified Long-Term Care insurance premiums) incurred by employees, their spouses, and qualifying dependents. As a defined contribution plan, the only funds available in the VEBA are the contributions made while employed and any investment returns on those funds. Once the funds in the VEBA are exhausted, the employee will no longer be able to reimburse their eligible healthcare expenses. You will receive claim filing instructions when your account becomes eligible to make reimbursements.

Financial/Retirement

Additional Information

More information, such as a list of qualified expenses and information on accessing your account can be found on the VEBA website: https://www.sanjoseca.gov/your-government/departments-offices/human-resources/benefits/veba.

For any questions about the VEBA Plan, including account or claims processing information, please contact Voya Financial Health Account Solutions at (833) 232-4673 or HASinfo@voya.com. Customer Service Associates are available Monday – Thursday from 8:00 a.m. to 6:00 p.m. ET and Friday 5:00 a.m. to 2:00 p.m. PT.

Additionally, you may contact Voya's onsite representative for additional assistance at (877) 464-4748 or visit a local VOYA representative every Wednesday in City Hall Tower, 4th Floor, for open office hours 9am-3pm, with lunch from 12pm-1pm.

For more information about the VEBA plan, please contact (408) 535-1285 or veba@sanjoséca.gov.

Plan Contacts

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

Kaiser Permanente (HMO and HDHP)		
Group # 887 | 230179	www.kp.org	800-464-4000
Anthem Blue Cross		
Group # 282397	www.anthem.com/ca	(844) 963-0448 (Non-HSA Plans) (844) 860 3535 (HSA Compatible Plan)
Delta Delta PPO		
Group # 2584	www.deltadentalins.com	(888) 335-8227
DeltaCare USA (Dental HMO)		
Group # 5643	www.deltadentalins.com	(800) 422-4234
Vision Service Plan (VSP)		
Group # 1211296	www.vsp.com	800-877-7195
The Standard (Life)		
Group #630976	www.standard.com	(t) 800-628-8600 (f) 888-414-0389
The Standard (Long Term Disability)		
Group #282971	www.standard.com	(t) 800-368-2859 (f) 800-378-6053
Generali Global Assistance (Travel Assistance)		
Group #D2STD	www.standard.com/travel	(800) 873-1414 (US, Canada, PR, US VI & Bermuda) 1+609.986.1234 (Everywhere else) medservices@assistamerica.com
Concern EAP		
sanjose	www.employees.concernhealth.com	(800) 344-4222

Plan Contacts

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

Voya Financial (457 Deferred Compensation & VEBA)		
Local Representatives (877) 464-4748	457: https://sanjose.beready2retire.com/ VEBA: HASinfo@voya.com	457: (800) 584-6001 VEBA: (833) 232-4673
P&A Group (FSA)		
FSA-Medical Reimbursement Account (MRA) FSA-Dependent Care Assistance Program (DCAP)	www.padmin.com	(800) 688-2611

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 that are not on the preferred drug list may not be covered.

SPECIALTY DRUG – Medication that requires close supervision and monitoring for serious and/or complex chronic conditions. These medications are often associated with very high costs and require special storage, handling, or dosing procedures.

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

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. Call your health plan's Member Services for more information.

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 carrier directly at the number at the back of your medical card.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in the County of San José's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in the County of San José's 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 31 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 31 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 31-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the County of San José's 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.

Important Plan Notices and Documents

AVAILABILITY OF PRIVACY PRACTICES NOTICE

We maintain the HIPAA Notice of Privacy Practices for the City of San José describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the HR, Benefits Division.

NOTICE OF CHOICE OF PROVIDERS

Health Maintenance Organization (HMO) plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, your carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your carrier directly. For children, you may designate a pediatrician as the primary care provider.

MICHELLE'S LAW

The City of San José 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, HR, Benefits Division 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.

NON-DISCRIMINATORY TESTING FOR CAFETERIA PLANS GOVERNED UNDER CODE SECTION 125

IRS requires each plan governed under "Code Section 125 cafeteria plans" to go through non-discriminatory testing each plan year to see if our plan passes. These plans offer a favorable pre-tax benefit, and the IRS requires plans to conduct special non-discriminatory testing on all plans that offer a favorable pre-tax benefit each year.

The codes nondiscrimination rules exist to prevent plans from being designed in such a way that it discriminates in favor of individuals who are either highly compensated employees or are otherwise key employees in the organization.

The plans will not pass the tests if the highly compensated employees or key employees elect more benefits under the plan than employees who are not highly compensated. This is called a "Concentration Test". If plans fail the concentrations testing, adjustments may be required to the yearly election amounts. Adjustments will not be made if the plan passes.

ACA DISCLAIMER

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 of your modified adjusted household income.

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your City of San José coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

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

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

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

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

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

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2024
Name of Entity/Sender:	CITY OF SAN JOSÉ
Contact-Position/Office:	Human Resources
Address:	200 E Santa Clara St, San Jose, CA 95113
Phone Number:	408-535-1285

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

(FOR USE BY SINGLE-EMPLOYER GROUP HEALTH PLANS)

** CONTINUATION COVERAGE RIGHTS UNDER COBRA**

CSJ COBRA Information

INTRODUCTION

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* aren't required to pay] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
•The parent-employee dies;
•The parent-employee's hours of employment are reduced;
•The parent-employee's employment ends for any reason other than his or her gross misconduct;
•The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
•The parents become divorced or legally separated; or
•The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

The end of employment or reduction of hours of employment;
Death of the employee;
[add if Plan provides retiree health coverage: Commencement of a proceeding in bankruptcy with respect to the employer;]; or
The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs. You must provide this notice to: [*Enter name of appropriate party*]. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.
There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.*]

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

Questions concerning your Plan, or your COBRA continuation coverage rights, should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

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

Plan contact information

Date:	10/18/2021
Name of Entity/Sender:	P&A Group
Contact-Position/Office:	P&A COBRA Division
Website	www.padmin.com
Phone Number:	(800) 688-2611

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

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

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

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

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

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

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

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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

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

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

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

CITY OF SAN JOSE
CAPITAL OF SILICON VALLEY

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