

EMPLOYEE BENEFITS GUIDE 2016



City of Clovis



what's inside

1 General Information

1. Introduction
1. Benefit Choices
2. Eligibility
4. Coverage Effective Dates
5. Changes in Coverage
6. Health Savings Account

7 Core Benefits

7. Medical
18. Dental
19. Vision
20. Basic Life

21 Other Benefits

21. Disability
22. Deferred Compensation
23. Other Benefits

24 Miscellaneous

24. Retirement
25. Important Notices
32. Contact Information

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

Please see page 28 for more details.

This document summarizes the benefits program. Full details of the benefit plans are contained in the official documents, which will govern in the case of any discrepancies.

INTRODUCTION

This Benefits Handbook is provided to employees as a comprehensive resource for the City of Clovis health and welfare benefits. This Handbook is not intended to be a contract (expressed or implied), nor is it intended to otherwise create any legally enforceable obligations on the part of the City, its agents, or its employees. The purpose of this Handbook is to summarize the City's employee benefits and the policies and procedures regarding these benefits. For the most detailed and up-to-date information, please refer to the appropriate plan document, evidence of coverage booklet, insurance policy or contract, as well as applicable rules, regulations, resolutions, ordinances and Memoranda of Understanding/Memoranda Agreement. These documents can be obtained by contacting the Personnel Department and on the City's website: www.cityofclovis.com under the Benefits tab.



BENEFIT CHOICES

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

ELIGIBILITY

Employees

Employees filling regular, full-time positions working 40 or more hours per week are eligible for coverage through the City. Regardless of the plan chosen by the employee, the City contributes a fixed amount toward the premium which is based upon 90% of the premium of the lowest cost medical HMO plan.

Extra help employees are eligible for health coverage for themselves and their children after two months of employment under the Kaiser DHMO (Deductible HMO) plan. Those employees who have been employed by the City for more than five years and who have worked more than 20 hours a week for two consecutive quarters will become eligible to enroll in any of the City's other health plans. Employees are responsible for paying the entire monthly premium at the beginning of the covered month. Premiums will not be deducted through payroll. Instead those enrolled will be billed through the Finance Department and will have to pay their premium through them.

Full-time employees may opt out of coverage with proof of other group coverage.

Active Employment

An employee will be deemed in "active employment" status on:

- Each day you are actually performing services for the City,
- Each day of a regular paid vacation
- A regular non-working day, provided you were actively at work on your last preceding scheduled regular working day and the following regularly scheduled day, and
- Any day on which you were absent from work during an approved FMLA leave or solely due to your own health status

Dependents

When enrolling dependents, appropriate documentation and/or proof of dependent status is required by the City and will be requested by Personnel.

Accepted forms of proof include: Marriage and Birth Certificates, Tax Returns, State Issued Declaration of Domestic Partnership, Adoption Certificate or Proof of Legal Guardianship.

An eligible dependent of an employee is:

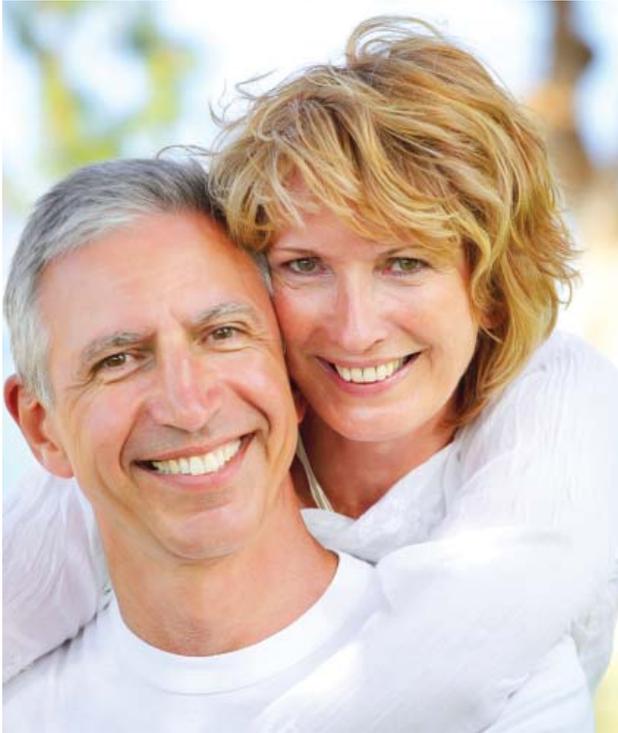
- A legally married spouse
- A registered domestic partner
- A Child, up to age 26 (for these purposes a "child" will include:
 - Biological Child
 - Stepchildren
 - Legally adopted children (including a child for whom legal adoption proceedings have been started), and
 - Any other child for whom you are required to provide health plan coverage under a Qualified Medical Child Support Order
 - A disabled child at any age, as long as he/she continues to meet the following conditions, as defined by Section 12102 of the Americans with Disabilities Act (ADA)

Non-Eligible Dependents

An eligible dependent does not include:

- A spouse following final decree of dissolution or divorce, or
- Any person who is on active duty in a military service, to the extent permitted by law.

ELIGIBILITY (continued)



Retirees

Retirees under the age of 65 are eligible to purchase health benefits through the City. The Retiree Medical/Prescription plan is subject to Council approval. To be eligible for the Retiree Medical / Prescription Plan, a retired/retiring employee must be continuously covered in the Medical / Prescription portion of the City's health plan through December 31 of the current plan year, as a full-time regular employee or a retired enrollee; or was continuously covered by a City-approved group medical / prescription plan as a full-time regular City employee immediately preceding retirement for the City.

Medicare while Working

If you are eligible to participate in the City's medical plans as an active employee and wish to continue working after reaching age 65, you have important options to consider when approaching Medicare eligibility. While you are still an active benefited employee under a City medical plan, you may be able to delay enrollment in some parts of Medicare without incurring a late enrollment penalty at a later date. Your City medical plan remains primary to Medicare while you are working.

For details of what's covered under Medicare, how to enroll, and your option regarding Medicare coverage, contact your local Social Security office or visit www.medicare.gov on the web.

Change in Dependent Eligibility

It is the employee's responsibility to notify the City's Personnel Department within 31 days or sooner of a dependent's change in status that would make the dependent eligible or ineligible for benefit coverage. Some examples of a change in dependent status are birth, death, adoption, divorce, or the obtaining of other coverage.

Continuation of Coverage (COBRA)

While you must delete your ineligible dependent within 30 days of the loss of eligibility, failure to delete your ineligible dependent within 60 days of loss of eligibility will result in a loss of continuation of coverage rights (COBRA) for your dependents.

COVERAGE EFFECTIVE DATES

New Full-Time Hire

Medical, Dental and Vision coverage are effective the date of hire when you complete and return the enrollment form within **30 days of the date of hire**. Life insurance is effective the first of the month following the date of hire.

New Extra Help Hire

All extra help employees will be eligible for health coverage for themselves and their children after two months of employment under the Kaiser DHMO plan. Those extra help employees who have been employed by the City for more than five years and who have worked more than 20 hours a week for two consecutive quarters will become eligible to enroll in any of the City's other health plans.

Open Enrollment

Once a year, usually during the month of November, the City holds an Open Enrollment period. During this time, you may change to a different medical plan, enroll in the dental plan, the vision plan or choose the cash in lieu option (waiver). You may also add or delete dependents to your medical, dental or vision plan.

Supporting documentation will be required by Personnel to add or delete new dependents.

Enrollment Instructions

When you are hired, you receive this Employee Benefits Handbook, as well as brochures describing your different benefits. You have 30 calendar days to make your choices and most of your benefits will be effective the date of hire. Read over all of the material carefully. If you have any questions and require assistance in making these important choices, you can contact the Personnel Department at 559.324.2725.

Here are some basic guidelines you need to keep in mind when going over these choices:

1. Review the section of this Handbook on medical plans, the health plan comparison, as well as the enrollment packets to determine which medical plan suits your health and financial needs.
2. Determine your life insurance needs and decide if you wish to buy additional coverage above what is provided by the City.
3. Study the Deferred Compensation information.
4. If you have medical coverage through another source, such as a spouse, you may want to consider the benefit waiver option. Proof of other group coverage will be required in order to qualify for this option.

Once you have made your choices, you should complete the appropriate enrollment forms and turn them into the Personnel Department with the required documentation within 30 calendar days of your hire date. Be sure to include all your eligible dependents and complete all beneficiary forms.

Change in Beneficiaries

Certain events in your life such as marriage, divorce, or a death in the family can affect who you name as your designated beneficiary for certain benefits. You may change your beneficiary(ies) at any time. If you wish to do so, you can obtain most beneficiary forms from HR. You can designate a beneficiary for:

- Deferred Compensation
- Life Insurance
- Retirement - CalPERS

Benefit Resources

You can access more information at:

- CityPub/Benefits/Health Benefits, or
- www.cityofclovis.com/Personnel/Benefits or
- contact the Personnel office at 559.324.2725.

CHANGES IN COVERAGE

Qualifying Events

You may experience certain events during the plan year that would allow you to change your or your dependent's medical coverage. If any of the following events occur, you must change your benefit coverage **within 30 days of the event**:

- Change in your legal marital or domestic partner status, including marriage, death of your spouse / domestic partner, divorce, legal separation or annulment.
- Change in the number of your dependents, including birth, adoption, placement for adoption or death of your dependent.
- Change in your employment status, including termination or commencement of employment of you, your spouse, your domestic partner or your dependent.
- Change in work schedule for you or your spouse / domestic partner, including an increase or decrease in the number of hours of employment, a switch between full-time and part-time status, a strike, lockout or commencement or return from an unpaid leave of absence.
- Your dependent satisfies or no longer meets the eligibility requirements for dependents.
- A change in the place of residence or worksite of you or your spouse / domestic partner (This move must affect your coverage options).
- You, your spouse / domestic partner or your dependents lose COBRA coverage.
- You, your spouse/domestic partner or your dependents enroll for Medicare or Medicaid or lose coverage under Medicare or Medicaid.
- If the plan receives a decree, judgment or court order, including a QMSCSO pertaining to your dependent, you may add the child to the plan or drop the child from the plan.
- A significant change in benefit or cost of coverage for you or your spouse/domestic partner.
- Your spouse/domestic partner employer provides the opportunity to enroll or change benefits during an open enrollment period.

Special Enrollment Rights as Provided by HIPAA

- You initially declined coverage under the plan because you had coverage under another plan, and subsequently incurred a loss of coverage under the other plan.
- Occurrence of certain events such as birth, adoption, placement for adoption or marriage.
- Eligibility for state premium subsidies under the Children's Health Insurance Program or State Children's Health Insurance Program.
- Loss of coverage under Medicaid, The Children's Health Insurance Program or State Children's Health Insurance Program.

HEALTH SAVINGS ACCOUNT

Enrollment into a High Deductible Health Plan (HDHP) is required to qualify for a Health Savings Account (HSA) with Wells Fargo.

An HSA is a voluntary savings account established for reimbursement of qualified medical expenses. HSAs were created to provide individuals with a tax saving benefit for certain medical expenses when covered under a HDHP.

An HSA is not a medical plan with a carrier. It is an individual savings account established for you to pay your medical expenses. It is able to reimburse the same category of eligible expenses as a Medical Flexible Spending Account, however your maximum available reimbursement is limited to your account balance.

Among the benefits of an HSA are:

- Contributions are exempt from Federal (not State) taxes;
- Interest and earnings are exempt from Federal taxes;
- Distributions are tax free when used for qualified medical expenses as listed under IRS Code 213 (d) such as co-pays, deductibles, dental vision expenses and more;
- Assets roll over from year to year – no “use it or lost it”;
- You can change the contribution at any time;
- The HSA is portable, so you can use the assets even if you leave the City’s employment.

In order to be eligible to contribute to an HSA, you must:

- be enrolled in an HDHP;
- have no other non-HDHP health coverage;
- not be enrolled in Medicare
- have not received VA medical benefits at any time over the past three months; and
- not be able to be claimed as a dependent on someone else’s tax return;
- are not contributing to a Medical Flexible Spending Account.

Even if you are no longer eligible to contribute to an HSA, whether you switch from a HDHP or leave the City employment, your HSA account remains active for the reimbursement of qualified medical expenses until it is depleted. Non medical withdrawals are considered taxable income and will have a 20% penalty if taken while you are under age 65.

Contribution maximums are set by the IRS. For the 2016 plan year the maximums are:

- Individual: \$3,350
- Family: \$6,750

An additional \$1,000 can be contributed over the age of 55.

By taking an active role in your health care, you can help contain health care costs. Here are some things you can do:

Stay Healthy

- **Quit smoking.** On average, smokers die 12 years sooner than non-smokers. In 2007, the national cost to treat tobacco-related illness was over \$50 billion.
- **Manage stress.** Take advantage of stress reduction classes offered by your health plan.
- **Exercise.** Incorporate 30 minutes of moderate exercise, such as walking, into your daily routine.
- **Eat more fruits, vegetables and whole grains.** Eat less sugar and saturated fat (red meat, dairy). Eliminate trans fats and fried foods.
- **Avoid heavy drinking.** National expenditures for alcohol-related illness amount to \$22.5 billion.
- **Get regular check-ups and preventative screenings as eligible.** Normal preventive screenings are covered at no cost to you under the health plans.
- **Keep track of your health concerns.** Write them down; do not forget to discuss with your doctor.
- **Follow doctor's orders.** Work together to speed recovery or manage a condition.
- **Complete a Health Risk Assessment.** Identify medical needs, share results with your doctor and be proactive about your care.
- **Complete an Advance Directive.** You do not need a lawyer. Document your medical care wishes for your loved ones, in case you can't speak for yourself.

www.ag.ca.gov/consumers/general/adv_hc_dir.htm.

Work with Your Doctor

- **Compare health plans.** Service areas, provider networks and out-of-pocket costs vary. Do your research and choose the plan that's best for you.
- **Wellness education.** Your plan and/or medical group may offer free or low cost fitness seminars or classes on wellness-related topics.
- **Consider generic drugs by mail order.** Take advantage of your plan's reduced costs for generic and mail order prescriptions.
- **E-mail your doctor.** Make use of any online tools provided by your doctor's office for communicating concerns or appointment scheduling. Some doctors may also schedule telephone consultations.
- **Pay attention to appointment reminders.** Don't skip appointments. If you must cancel, notify your doctor's office in advance.
- **Outpatient surgery.** When possible, your doctor may schedule you to have surgery on an outpatient basis.
- **Chronic condition management programs.** These services can help you and your family become better educated and coordinate care for diabetes, asthma, heart health, cancer, obesity and other conditions.

MEDICAL (continued)

Health Insurance Options

Health insurance is often taken for granted. It's one of those benefits which we often don't really appreciate until we need it. The City offers a choice of four different health plans: two HMO plans 1) Kaiser Permanente 2) Anthem Blue Cross; one Preferred Provider Organization (PPO) plan and a High Deductible Health Plan (HDHP) through Anthem Blue Cross.

Please note: All plans cover preventive care services at no cost to the participant.

- **HMO.** These plans provide a wide range of health care services using a managed care approach. When you enroll in an HMO, you must use providers who are affiliated with the HMO. You will not have to meet a deductible or file claim forms and will only be responsible for a small copay at the time of service.
- **PPO.** This plan allows for freedom of choice when choosing your providers. There is a deductible that needs to be met prior to services being covered. By choosing participating providers you will reduce your out of pocket costs.
- **High Deductible Health Plan (HDHP).** This plan has no monthly premium for the employee, but has a higher plan deductible. A qualified HDHP plan has deductible and out of pocket maximums that are set by the IRS each year.

If you enroll in the High Deductible Health Plan you have the option of opening a Health Savings Account (HSA) with Wells Fargo, as long as you meet the eligibility guidelines.

Your Responsibility

There are certain regulations that apply to the health, dental and vision plans. You have the option of enrolling in the medical, dental and vision plan or waiving the medical plan (with proof of other coverage) and enrolling in the dental and vision.

- **Enrollment.** You must complete a universal enrollment form for Kaiser Permanente or Anthem Blue Cross. You will also have to complete a vision enrollment form. A verbal request for coverage is not sufficient, even if you were previously enrolled. If your coverage has been canceled due to a leave of absence (without pay), you must complete an enrollment form and return it to the Personnel Department **within 30 calendar days** of eligibility. If you are covered under another plan such as a spouse's plan, and lose that coverage, you have 30 calendar days to enroll in a City health plan. Otherwise you will have to wait until the Open Enrollment period.
- **Dependents.** You may only add new dependents to your medical, dental and vision plans by completing the appropriate change form and returning it to the Personnel Department **within 30 calendar days** of birth, adoption, marriage, or proof of domestic partner registration. Otherwise you will have to wait until Open Enrollment.
- **Termination of Coverage.** Dependents that are no longer eligible must be dropped from the City's group plan(s). It is your responsibility to notify the City within 30 calendar days when a dependent child, spouse or domestic partner is no longer eligible by completing the appropriate change form and returning it to the Personnel Department. Deleted dependents may continue coverage under the COBRA law.
- **Waiver Option.** If you are a full-time employee and have other health or dental / vision coverage under another group plan, for example through your spouse, you have the option of waiving coverage

MEDICAL (continued)

and receiving a cash payment. For exact amount of cash, see your bargaining unit's Health Benefits Summary. The cash payment is taxable and will be included in your paycheck.

You may only apply for the waiver option within 30 calendar days of your hire date or during the Open Enrollment period or if you experience another qualifying event. To be eligible for the waiver, you must complete the California Waiver Form and return it to the Personnel Department along with proof of other coverage.

- **Late Entrants.** Employees who decline medical coverage for themselves and/or their dependents during the initial enrollment period and then, more than 31 days later, request coverage, will be considered to be Late Entrants. Late Entrants may be subject to an exclusion from coverage until next open enrollment. However, an eligible employee will not be considered a Late Entrant for employee and/or dependent coverage if late enrollment is made under one of the circumstances described below

and any required information or proof is furnished.

- **Exceptions.**

1. Termination of Other Health Coverage – Request for enrollment is made within 30 days after termination of other health coverage, and (a) the employee certifies that enrollment under this plan was initially declined solely due to the other coverage; and (b) termination of the other group coverage due to termination of employment or eligibility, the involuntary termination of the previous coverage, cessation of the employer's contribution towards the individual's coverage, death of spouse or divorce; (c) significant change in cost or scope of coverage in the spouse's employer plan.
2. Court order: Request for enrollment is made within 30 days after issuance of court order that coverage be provided for the spouse and/or minor child(ren) of a covered employee.



MEDICAL (continued)

Employees may enroll in any of the following plans.

Care of Services	Anthem Blue Cross HMO	Kaiser Permanente HMO
General Plan Information		
• Annual Deductible (<i>Individual / Family</i>)	\$0 / \$0	\$0 / \$0
• Coinsurance	100%	100%
• Office Visit / Exam	\$15 co-pay	\$15 co-pay
• Outpatient Specialist Visit	\$15 co-pay	\$15 co-pay
• Annual Out-of-Pocket Limit (<i>Individual / Family</i>)	\$1,000 / \$2,000	\$1,500 / \$3,000
• Lifetime Plan Maximum	Unlimited	Unlimited
• Primary Care Physician Election Required	Yes	Yes
Outpatient Services		
• Well-Child Care	100%	100%
• Immunizations	100%	100%
• Well-Woman Exams	100%	100%
• Mammograms	100%	100%
• Adult Periodic Exams with Preventive Tests	100%	100%
• Diagnostic X-Ray and Lab Tests	100%	\$10 co-pay/encounter 100% certain preventive x-ray and lab \$50 co-pay MRI, CT and PET
Maternity Care		
• Pregnancy and Maternity Care (<i>Pre-Natal Care</i>)	100%	100%
Inpatient Hospital Services		
• Inpatient Hospitalization	100%	100%
• Pre-Authorization of Services Required	Yes	Yes
• Semi-Private Room & Board; including Services and Supplies	100%	100%
Surgical Services		
• Outpatient Facility Charge	100%	\$15 co-pay/procedure
Emergency Services		
• Emergency Room	\$100 co-pay (waived if admitted)	\$100 co-pay (waived if admitted)
• Ambulance (<i>air or ground</i>)	100%	\$100 co-pay
Urgent Care		
• Urgent Care Facility	\$15 co-pay	\$15 co-pay
Mental Health Benefits		
• Inpatient Care	100%	100%
• Outpatient Care	\$15 co-pay	\$15 co-pay individual therapy; \$7 co-pay group therapy

See the Evidence of Insurability (EOC) for more benefit details.

The information on this page is intended to be a summary of your benefit provisions, limitations and exclusions. Please review your Summary Plan Description (SPD) for a complete summary of benefits.

MEDICAL (continued)

Care of Services	Anthem Blue Cross HMO	Kaiser Permanente HMO
Substance Abuse		
• Inpatient Care (<i>Inpatient Hospitalization, Inpatient Detoxification Services</i>)	100%	100%
• Outpatient Care (<i>Outpatient Services</i>)	\$15 co-pay	\$15 co-pay individual therapy; \$5 co-pay group therapy
Prescription Drugs	Through US Script	
• Retail		
– Generic	\$10 co-pay	\$10 co-pay
– Brand (<i>Formulary / Preferred</i>)	\$20 co-pay	\$30 co-pay
– Brand (<i>Non-Formulary / Non-Preferred</i>)	\$35 co-pay	\$30 co-pay
– Number of Days Supply	30 days	30 days
• Mail Order		
– Generic	\$20 co-pay	\$20 co-pay
– Brand (<i>Formulary / Preferred</i>)	\$40 co-pay	\$60 co-pay
– Brand (<i>Non-Formulary / Non-Preferred</i>)	\$60 co-pay	\$60 co-pay
– Number of Days Supply	90 days	100 days
Other Services and Supplies		
• Durable Medical Equipment and Prosthetic Devices	100% covered	80% covered
• Home Health Care	\$15 co-pay; up to 100 visits/cal year	100%; up to 100 visits/cal year
• Skilled Nursing or Extended Care Facility	100%; up to 100 days/cal year	100%; up to 100 days/cal year
• Hospice Care	100%	100%
• Chiropractic Services	\$15 co-pay; up to 30 visits/cal year	\$10 co-pay; up to 30 visits/cal year
• Acupuncture	\$15 co-pay	
Vision		
• Exam	Not covered	100%
Hearing		
• Screening	100%	100%
Infertility		
• Diagnosis, Treatment	See Plan Certificate	See Plan Certificate
Outpatient Rehabilitative therapy Services		
• Physical, Occupational, Speech	\$15 co-pay	\$15 co-pay

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MEDICAL (continued)

Care of Services	Anthem Blue Cross High Deductible Health Plan	
	In-Network	Out-of-Network
General Plan Information		
• Annual Deductible <i>(Individual / Family)</i>	\$3,000 combined in/out-of-network / \$6,000 combined in/out-of-network	
• Coinsurance	100%	50%
• Office Visit / Exam	100%	50%
• Outpatient Specialist Visit	100%	50%
• Annual Out-of-Pocket Limit <i>(Individual / Family)</i>	\$3,000 / \$6,000	\$5,000 / \$10,000
• Deductible Included in Out-of-Pocket Limits	Yes	Yes
• Lifetime Plan Maximum	Unlimited	Unlimited
Outpatient Services		
• Well-Child Care	100%; deductible waived	50%
• Immunizations	100%; deductible waived	50%
• Well-Woman Exams	100%; deductible waived	50%
• Mammograms	100%; deductible waived	50%
• Adult Periodic Exams with Preventive Tests	100%; deductible waived	50%
• Diagnostic X-Ray and Lab Tests	100%	50%
Maternity Care		
• Pregnancy and Maternity Care <i>(Pre-Natal Care)</i>	100%	50%
Inpatient Hospital Services		
• Inpatient Hospitalization	100%	50%
• Pre-Authorization of Services Required	Yes	Yes
• Semi-Private Room & Board; including Services and Supplies	100%	50%
Surgical Services		
• Outpatient Facility Charge	100%	50%; up to \$350/day
Emergency Services		
• Emergency Room	100%	100%
• Ambulance <i>(air or ground)</i>	100%	100%
Urgent Care		
• Urgent Care Facility	100%	50%
Mental Health Benefits		
• Inpatient Care	100%	50%; up to \$600/day
• Outpatient Care	100%	50%

The information on this page is intended to be a summary of your benefit provisions, limitations and exclusions. Please review your Summary Plan Description (SPD) for a complete summary of benefits.

MEDICAL (continued)

Care of Services	Anthem Blue Cross High Deductible Health Plan	
	In-Network	Out-of-Network
Substance Abuse		
• Inpatient Care (<i>Inpatient Hospitalization, Inpatient Detoxification Services</i>)	100%	50%
• Outpatient Care (<i>Outpatient Services</i>)	100%	50%
Prescription Drugs		
• Retail		
– Generic	100%	50% + amount not covered
– Brand (<i>Formulary / Preferred</i>)	100%	50% + amount not covered
– Brand (<i>Non-Formulary / Non-Preferred</i>)	100%	50% + amount not covered
– Number of Days Supply	30 days	30 days
• Mail Order		
– Generic	100%	Not covered
– Brand (<i>Formulary / Preferred</i>)	100%	Not covered
– Brand (<i>Non-Formulary / Non-Preferred</i>)	100%	Not covered
– Number of Days Supply	90 days	N/A
Other Services and Supplies		
• Durable Medical Equipment and Prosthetic Devices	100%	50%
• Home Health Care	100%; up to 100 visits/cal year	50%; up to 100 visits
• Skilled Nursing or Extended Care Facility	100%; up to 100 days	50%; up to 100 days
• Hospice Care	100%	Not covered
• Chiropractic Services	100%; 24 visits combined with rehab therapies	50%; 24 visits combined with rehab therapies
• Acupuncture	Not covered	Not covered
Vision		
• Exam	100%	Not covered
Hearing		
• Screening	100%	Not covered
Infertility		
• Diagnosis, Treatment	Not covered	Not covered
Outpatient Rehabilitative therapy Services		
• Physical, Occupational, Speech	100%	50%

The information on this page is intended to be a summary of your benefit provisions, limitations and exclusions. Please review your Summary Plan Description (SPD) for a complete summary of benefits.

MEDICAL (continued)

Care of Services	Anthem Blue Cross PPO 500-80/60	
	In-Network	Out-of-Network
General Plan Information		
• Annual Deductible (<i>Individual / Family</i>)	\$500 combined in/out-of-network / \$1,000 combined in/out-of-network	
• Coinsurance	80%	60%
• Office Visit / Exam	\$35 co-pay	60%
• Outpatient Specialist Visit	\$35 co-pay	60%
• Annual Out-of-Pocket Limit (<i>Individual / Family</i>)	\$3,000 / \$6,000	\$10,000 / \$20,000
• Deductible Included in Out-of-Pocket Limits	Yes	Yes
• Lifetime Plan Maximum	Unlimited	Unlimited
Outpatient Services		
• Well-Child Care	100%	60%
• Immunizations	100%	60%
• Well-Woman Exams	100%	60%
• Mammograms	100%	60%
• Adult Periodic Exams with Preventive Tests	100%	60%
• Diagnostic X-Ray and Lab Tests	80% diagnostic testing 100% routine lab services	60%
Maternity Care		
• Pregnancy and Maternity Care (<i>Pre-Natal Care</i>)	80%	60%
Inpatient Hospital Services		
• Inpatient Hospitalization	\$250/admission + 20%	60%; up to \$600/day
• Pre-Authorization of Services Required	Yes	Yes
• Semi-Private Room & Board; including Services and Supplies	\$250/admission + 20%	60%; up to \$600/day
Surgical Services		
• Outpatient Facility Charge	\$125/surgery + 20%	60%; up to \$350/day
Emergency Services		
• Emergency Room	80%	80%
• Ambulance (<i>air or ground</i>)	80%	80%
Urgent Care		
• Urgent Care Facility	\$35 co-pay	60%
Mental Health Benefits		
• Inpatient Care	\$250/admission + 20%	60%; up to \$600/day
• Outpatient Care	\$35 co-pay	60%

The information on this page is intended to be a summary of your benefit provisions, limitations and exclusions. Please review your Summary Plan Description (SPD) for a complete summary of benefits.

MEDICAL (continued)

Care of Services	Anthem Blue Cross PPO 500-80/60	
	In-Network	Out-of-Network
Substance Abuse		
• Inpatient Care (<i>Inpatient Hospitalization, Inpatient Detoxification Services</i>)	\$250/admission + 20%	60% up to \$600/day
• Outpatient Care (<i>Outpatient Services</i>)	\$35 co-pay	60%
Prescription Drugs (<i>through US Script</i>)		
• Retail		
– Generic	\$10 co-pay	\$10 co-pay + amount over network allowance
– Brand (<i>Formulary / Preferred</i>)	\$20 co-pay	\$20 co-pay + amount over network allowance
– Brand (<i>Non-Formulary / Non-Preferred</i>)	\$35 co-pay	\$35 co-pay + amount over network allowance
– Number of Days Supply	30 days	30 days
• Mail Order		
– Generic	\$20 co-pay	Not covered
– Brand (<i>Formulary / Preferred</i>)	\$40 co-pay	Not covered
– Brand (<i>Non-Formulary / Non-Preferred</i>)	\$60 co-pay	Not covered
– Number of Days Supply	90 days	N/A
Other Services and Supplies		
• Durable Medical Equipment and Prosthetic Devices	80%	80%
• Home Health Care	80%; 100 visits/cal year	80%; 100 visits/cal year
• Skilled Nursing or Extended Care Facility	80% ; 100 days/cal year	80%; 100 days/cal year
• Hospice Care	80%	Not covered
• Chiropractic Services	\$25 co-pay; 12 visits/cal year	60%; 12 visits/cal year
• Acupuncture	80%	60%
Vision		
• Exam	Not covered	Not covered
Hearing		
• Screening	100%	60%
Infertility		
• Diagnosis, Treatment	Not covered	Not covered
Outpatient Rehabilitative therapy Services		
• Physical and Occupational	\$25 co-pay	60%
• Speech	\$35 co-pay	60%

The information on this page is intended to be a summary of your benefit provisions, limitations and exclusions. Please review your Summary Plan Description (SPD) for a complete summary of benefits.

MEDICAL (continued)

Extra Help Employees

Care of Services	Kaiser Permanente DHMO
General Plan Information	
• Annual Deductible <i>(Individual / Family)</i>	\$4,500 / \$9,000
• Office Visit / Exam	60%
• Outpatient Specialist Visit	60%
• Annual Out-of-Pocket Limit <i>(Individual / Family)</i>	\$6,000 / \$12,000
• Lifetime Plan Maximum	Unlimited
• Primary Care Physician Election Required	Yes
Outpatient Services	
• Well-Child Care	100%
• Immunizations	100%
• Well-Woman Exams	100%
• Mammograms	100%
• Adult Periodic Exams with Preventive Tests	100%
• Diagnostic X-Ray and Lab Tests	60%
Maternity Care	
• Pregnancy and Maternity Care <i>(Pre-Natal Care)</i>	100%
Inpatient Hospital Services	
• Inpatient Hospitalization	60%
• Pre-Authorization of Services Required	Yes
• Semi-Private Room & Board; including Services and Supplies	60%
Surgical Services	
• Outpatient Facility Charge	60%
Emergency Services	
• Emergency Room	60%
• Ambulance <i>(air or ground)</i>	60%
Urgent Care	
• Urgent Care Facility	60%
Mental Health Benefits	
• Inpatient Care	60%
• Outpatient Care	60%

See the Evidence of Insurability (EOC) for more benefit details.

The information on this page is intended to be a summary of your benefit provisions, limitations and exclusions. Please review your Summary Plan Description (SPD) for a complete summary of benefits.

MEDICAL (continued)

Extra Help Employees

Care of Services	Kaiser Permanente DHMO
Substance Abuse	
• Inpatient Care (<i>Inpatient Hospitalization, Inpatient Detoxification Services</i>)	60%
• Outpatient Care (<i>Outpatient Services</i>)	60%
Prescription Drugs	
• Deductible	\$250
• Retail	
– Generic	70%
– Brand (<i>Formulary / Preferred</i>)	60%
– Brand (<i>Non-Formulary / Non-Preferred</i>)	60%
– Number of Days Supply	30 days
• Mail Order	
– Generic	70%
– Brand (<i>Formulary / Preferred</i>)	60%
– Brand (<i>Non-Formulary / Non-Preferred</i>)	60%
– Number of Days Supply	100 days
Other Services and Supplies	
• Durable Medical Equipment and Prosthetic Devices	Not covered
• Home Health Care	60%; up to 100 visits/cal year
• Skilled Nursing or Extended Care Facility	60%; up to 100 days/cal year
• Hospice Care	60%
Vision	
• Exam	60%
Hearing	
• Screening	60%
Infertility	
• Diagnosis, Treatment	Not covered
Outpatient Rehabilitative therapy Services	
• Physical, Occupational, Speech	60%

The information on this page is intended to be a summary of your benefit provisions, limitations and exclusions. Please review your Summary Plan Description (SPD) for a complete summary of benefits.

DENTAL

The City has established a self-funded dental program to assure that you and your family have adequate coverage available for the most common dental procedures.

The City will continue to offer two (2) different PPO networks to choose from, giving you more opportunities to find a participation PPO dentist which can reduce your out of pocket expenses for services. The plan does still provide the option to use any dentist of your choice.

In addition to expanding your network choices, the City is enhancing the benefit to 100% coverage for exams and bitewing x-rays when using a PPO provider.

The choice of which network to use can only be done

during the open enrollment period and will be the same network for all family members. To see if your dentist is a participating provider in either network please contact either Connection Dental or Health Smart.

- Connection Dental: www.ppousa.com or call 877.277.6872
- Health Smart: www.healthsmart.com or call 800.687.0500

If you do not chose a network at the beginning of the year you will be automatically assigned to the current Connection Dental network.

Type of Benefit	Connection Dental / HealthSmart	
	In Network	Out-of-Network *
Deductible	\$0	
Calendar Year Max	\$2,000	
Preventive Care		
• Exams and Cleanings	100%	80%
• Bitewing X-Rays	100%	80%
• Full Mouth X-Ray Series or Panoramic X-Ray	80%	80%
• Sealants	80%	80%
Basic Restorative		
• Anterior Composite (ADA 2330)	80%	80%
• Molar Root Canal (ADA 3330)	80%	80%
• Periodontic Treatment (ADA 4210)	80%	80%
• Surgical Extraction (ADA 7210)	80%	80%
Major Restorative		
• Crown (ADA 2750)	80%	80%
• Denture (ADA 5110/5120)	80%	80%
• Fixed Bridge Crown (ADA 6750)	80%	80%
• Implants	80%; \$1,000 annual max; included in the cal year max	80%; \$1,000 annual max; included in the cal year max

* Out of Network dentists are based on Usual, Customary, & Reasonable Fees (UCR); Amounts over the UCR are the member's responsibility.

The information on this page is intended to be a summary of your benefit provisions, limitations and exclusions. Please review your Summary Plan Description (SPD) for a complete summary of benefits.

VISION

The City offers a self funded vision plan through **MES Vision** that allows you to go to any provider, however your benefits are greater if you use one of the MES Vision contracted providers.

Plan Benefits	In Network	Out-of-Network
Frequency of Services		
• Vision Exam	Once every 12 months	
• Eyeglass Lenses	Once every 12 months	
• Frames	Once every 24 months	
• Contact Lenses	Once every 12 months	
Co-pay (per Insured)		
• Vision Exam	\$25	\$25
• Eyeglass Lenses/Frames	\$0	\$0
Benefits and Allowances		
• Vision Exam		
– Ophthalmologist (M.D.)	Covered in full	\$40 allowance
– Optometrist (O.D.)	Covered in full	\$40 allowance
• Materials – Eyeglass Lenses		
– Single Vision	Covered in full	\$30 allowance
– Bifocals	Covered in full	\$50 allowance
– Trifocals	Covered in full	\$65 allowance
– Lenticular	Covered in full	\$120 allowance
• Materials – Frames (<i>in lieu of contacts</i>)	\$80 retail allowance	\$32 retail allowance
• Contact Lenses		
– Non-Elective	Covered in full	\$200 allowance for hard lenses; \$250 allowance for soft lenses
– Elective	\$150 allowance	\$120 allowance

The information on this page is intended to be a summary of your benefit provisions, limitations and exclusions. Please review your Summary Plan Description (SPD) for a complete summary of benefits.

BASIC LIFE

Basic Life

The City provides a Basic life insurance benefit through The Standard Insurance Company, at no cost to the employee for those classified as full-time salaried employees. The plan will pay the following amount to your beneficiary at the time of death:

- All Non-Management and Memorial District – \$25,000

If you are a management member, Memorial District, or Council member see Personnel for the benefit amount.

If you die while actively employed with the City, your beneficiaries will receive a cash benefit. There is also a living benefit option that provides payment of a partial benefit for terminally ill insured employees.

Voluntary Life

Additional employee paid life insurance is also available through The Standard Insurance Company. You may apply for additional coverage in multiples of \$5,000 from \$10,000 to \$500,000. You may apply for coverage up to \$100,000 without evidence of insurability within 30 day of the hire date. After the initial eligibility period, all amounts are subject to approval based on medical evidence.

As long as you are covered for the Basic Life coverage, you may apply for coverage for your spouse and dependent children in the following amounts

- **Spouse.** Increments of \$5,000 with coverage between \$5,000 to \$250,000
- **Children.** \$2,000 of coverage

The amount for either spouse or children cannot exceed 50% of the amount of your life insurance.

Coverage cost varies with age. Your monthly premium will not change until the plan anniversary date following the year in which you move to a new age bracket.

Don't Forget to Name a Beneficiary

A beneficiary is the person or persons who will be paid if you die while covered by the plan. A person becomes your beneficiary only if you have named them on the card you signed when you enrolled. If you are married and not naming your spouse as the beneficiary, the spouse must sign an acknowledgement. You may change your beneficiary at any time by completing a new form and returning it to Personnel.

Conversion (Termination of Employment)

You may convert your Basic or Supplemental Life insurance to individual coverage when you leave City employment. You must apply within 30 days of your termination date. If you are interested in conversion contact the Personnel office.



State Disability Insurance (SDI)

SDI is available for all non-management and non-safety employees. SDI is employee paid by payroll deduction. If you are unable to work due to a non-work related accident or illness, you are eligible to receive disability income for up to one year.

The City coordinates SDI benefits with EDD for all eligible full-time salaried employees. While you are out on disability, you are required to use your available leave balances in order to receive your regular salary and benefits through payroll, unless you notify Personnel. When you receive payment from EDD, you are required to bring those payments in to the City, at which time you will be reimbursed your leave balances in the amount of the payment. You cannot receive pay from EDD and pay from the City for the same period of time.

If you anticipate being out on disability or it occurs suddenly, please contact the Personnel Office for copies of EDD forms for you to file. Be sure to keep your supervisor informed of your status and provide him/her copies of any medical status notes provided by your doctor.

DEFERRED COMPENSATION

A governmental 457(b) deferred compensation plan is a retirement savings plan that allows eligible employees to supplement any existing retirement and pension benefits by saving and investing before-tax dollars through a voluntary salary contribution. Contributions and any earnings on contributions are tax-deferred until money is withdrawn. Distributions are usually taken during retirement, when many participants are typically receiving less income and may be in a lower income tax bracket than while working. Distributions are subject to ordinary income tax. The City offers two options through ICMA:

- **457 (b) Deferred Compensation Plan.** A retirement savings plan that allows participants to lower their current taxable income by making pre-tax contributions up to the annual limit specified by the IRS.
- **The VantageCare Retirement Health Savings Plan.** An employer sponsored health benefit savings vehicle for certain groups that allows participants to accumulate assets to pay for medical expenses during retirement on a tax-free basis when assets are used to pay for tax qualified medical benefits.

Eligibility

All permanent City employees are eligible.

Contributions

In 2016, the maximum contribution is 100% of your includable compensation up to the limit specified by the IRS.

You may choose between two different options to catch up and contribute more during the final years of your career:

- **The Standard Catch-Up.** Allows participants in the three years prior to normal retirement age to contribute up to double the annual contribution limit. The additional amount you may be able to contribute under the Standard Catch-Up option will depend upon the amounts that you were eligible to contribute in previous years but did not.
- **Age 50 Catch-Up.** Employees turning age 50 or older in 2015 may contribute an additional amount above the normal limit as specified annually by the IRS.

Rollovers

If you leave City employment, you may roll over your account balance to another 401(a), 401(k), 403(b) or another eligible governmental 457(b) plan if your new employer's plan accepts such rollovers. You may also roll over your account balance to an IRA.

Distributions

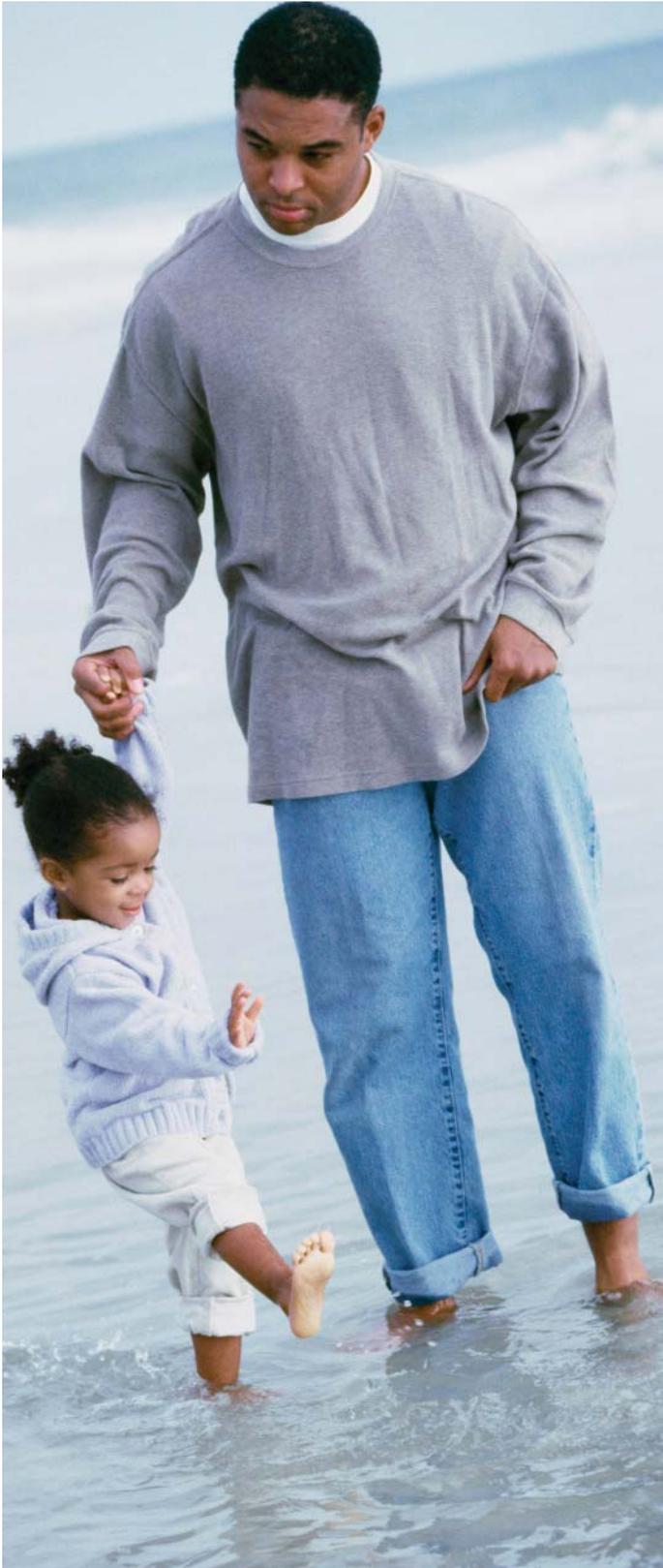
Qualifying distributions include:

- Retirement
- Permanent Disability
- Unforeseeable emergency as defined by the IRS
- Severance of employment as defined by the IRS
- Attainment of age 70 ½
- Death (upon which your beneficiary receives your benefits)
- Transfer to purchase service credits.

Taxes

Contributions are taken out of your paycheck on a pre-tax basis. Distributions are taxable as ordinary income during the years in which they are distributed or made available to you or your beneficiary(ies).

OTHER BENEFITS



Employee Assistance Program (EAP)

No one gets through life without problems. Each of us at one time or another faces hardship, tragedy, disappointment, or loss. To help deal with tough situations, the City offers an Employee Assistance Program administered by Insight, at no cost to the employee.

Insight is a short-term, confidential counseling and referral service designed to help you and your eligible household members resolve personal problems that may be interfering with your work or home life.

Insight offers no cost, confidential, short term counseling/referrals every six months for a variety of issues related to:

- Employment concerns
- Family / couples relationship / parenting issues
- Elder care
- Grief / life transitions
- Depression / anxiety

For services call 559.226.7437 or 800.422.5322. They also offer many life resources through the internet at www.insighteap.com.

Fresno County Federal Credit Union

As a City employee you are eligible to join the member owned Fresno County Federal Credit Union. The Credit Union is member owned and offers lower rates on loans, higher savings rates and lower financial planning cost.

Benefits include:

- Financial Planning
- Shared Certificates of Deposit
- Money Market Advantage
- Retirement Accounts
- Loans

CalPERS

- **Employees Hired On or After January 1, 2013.** All employees hired after January 1, 2013 are subject to AB340 and AB197, California Public Employee Pension Reform Act of 2013. For Miscellaneous employees in this category, their retirement formula is 2% at age 62. For Safety employees in this category, their retirement formula is 2.7% at age 57.
- **Employees Hired Before January 1, 2013.** Your CalPERS retirement benefit is based on a formula that takes into account your age, years of service, and highest year's salary. For Miscellaneous employees, the retirement formula is 2.7% at age 55. For Safety employees, the retirement formula is 3% at age 50. Should you become disabled prior to retirement age, you may be eligible for a disability retirement benefit.

To apply for CalPERS retirement, obtain a CalPERS Retirement Application Booklet online at www.mycalpers.ca.gov or from the Personnel office. The "Employer Certification" is completed by the Personnel Department. The completed form should be mailed directly to CalPERS.

Employees approaching retirement are encouraged to attend a CalPERS Retirement Planning Workshop. You can call CalPERS at 888.225.7377 for details.

CalPERS Optional Provisions

The City of Clovis elected and elects to be subject to the following optional provisions:

- a) Section 21574 (Fourth Level of 1959 Survivor Benefits).
- b) Section 20903 (Two Years Additional Service Credit under very limited circumstances for some individuals).
- c) Section 20965 (Credit for Unused Sick Leave).
- d) Section 20042 (One-Year Final Compensation). For members subject to PEPR, use the three-year final compensation.
- e) Section 20503 (To Remove the Exclusion of Persons Compensated on an Hourly Basis Hired on or After April 1, 1967, Prospectively from September 7, 2006)
- f) Section 20325 (Optional Membership for Part-Time Employees) for local miscellaneous members only.
- g) Section 21547.7 (Alternate Death Benefit for Local Fire Members Credited with 20 or More Years of Service)
- h) Section 21548 (Pre-Retirement Option 2W Death Benefit).
- i) Section 21024 (Military Service Credit as Public Service).
- j) Section 20516 (Employees Sharing Cost of Additional Benefits).

Medicare Eligible Retirees

Employees who are approaching Medicare age or have spouses approaching Medicare age or who may become Medicare eligible for other reasons such as disability need to go online and/or contact the Medicare Office as soon as possible in order to determine the rules for their eligibility. In some cases, there is a fairly short window of time to sign up for benefits to be eligible or to avoid significant ongoing penalties. Do your research and planning early to preserve all of your options and get the most for your healthcare dollar.

Retirees over the age of 65 are encouraged to contact an independent medicare broker or a Medicare exchange, such as One Exchange (formally known as Extend Health) at www.medicare.oneexchange.com or 866.322.2824.

IMPORTANT NOTICES

Newborns and Mothers Health Protection Act (NMHPA)

A health plan which provides benefits for pregnancy delivery generally may not restrict benefits for a covered pregnancy Hospital stay (for delivery) for a mother and her newborn to less than 48 hours following a vaginal delivery or 96 hours following a Cesarean section. Also, any utilization review requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prosthetics, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 559.324.2725.

Grievance / Appeals

You have a right to two levels of appeal with our carriers, and a right to a response within a reasonable amount of time. However, also know that if a claim is not submitted within a reasonable time, the carriers have a right to deny that claim. The California Department of Managed Health Care (DMHC) is responsible for regulating health care plans. If you have a grievance against your health plan, you should first telephone your health plan and use your plan's appeal process before contacting the DMHC. Please review each contract for specific procedures on how to submit an appeal to a claim. This does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency or that has not been satisfactorily resolved by your health plan, or that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for Independent Medical Review for an impartial review of medical decisions made by a health plan related to medical necessity, coverage decisions for treatments that are experimental in nature, and payment disputes for emergency or urgent medical services. The DMHC can be reached at 888.HMO.2219 (TDD 877.688.9891) or hmohelp.ca.gov.

COBRA Continuation Coverage

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

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally 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 cover must pay for COBRA continuation coverage.

If you're an Employee, you'll become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

IMPORTANT NOTICES (continued)

- 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."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

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

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a Covered Employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be furnished by U.S. mail, registered or certified, postage prepaid and properly addressed to the Plan Administrator.

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

ELECTION AND ELECTION PERIOD

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

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

IMPORTANT NOTICES (continued)

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

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

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

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

OTHER OPTION BESIDES COBRA CONTINUATION COVERAGE

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

IF YOU HAVE QUESTIONS

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, 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 dol.gov/ebsa. (Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit 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.

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying

IMPORTANT NOTICES (continued)

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

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

The Plan will notify the Qualified Beneficiary in writing, of any termination of COBRA coverage based on the criteria stated in this subsection that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate. Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description for more information.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

If you declined coverage while Medicaid or CHIP is in effect, you may be able to enroll yourself and / or your Dependents in this plan if you or your Dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

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

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

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

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Clovis has determined that the prescription drug coverage offered by the City of Clovis Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable

IMPORTANT NOTICES (continued)

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 current City of Clovis coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current City of Clovis coverage, be aware that you and your Dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with the City of Clovis 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 will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Clovis changes. You also may request a copy

of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at 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).

Name of Entity / Sender: City of Clovis
Contact: Andy Soldo, Personnel
Address: 1033 5th Avenue
Clovis, CA 93612
Phone: 559.324.2728

IMPORTANT NOTICES (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins November 1, 2015 to January 31, 2016.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, or offers medical coverage that is not “Affordable” or does not provide “Minimum Value.” If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

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

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

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

IMPORTANT NOTICES (continued)

PART B: EXCHANGE APPLICATION INFORMATION

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

3. Employer name City of Clovis	4. Employer Identification Number (EIN) 94-6000311	
5. Employer address 1033 Fifth Street	6. Employer phone number 559.324.2725	
7. City Clovis	8. State CA	9. ZIP code 93612
10. Who can we contact about employee health coverage at this job? Andy Soldo		
11. Phone number (if different from above) 559.324.2728	12. Email address andys@cityofclovis.com	

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

The City of Clovis Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Andy Soldo at 559.324.2728.

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

Please see the Summary Plan Description for more information.



CONTACT INFORMATION

Below is a listing of the telephone numbers you can call with questions about the plans available to you. You can also use the web-site (if available) to access information from providers for the various plans.

Plan	Phone Number	Web Site
City of Clovis Personnel Office	559.324.2725 559.324.2865 (fax)	www.ci.clovis.ca.us
<ul style="list-style-type: none"> 1033 Fifth Street, Clovis, CA 93612 		
Medical		
<ul style="list-style-type: none"> Kaiser Permanente 	800.464.4000	www.kp.org
<ul style="list-style-type: none"> Anthem Blue Cross 		www.anthem/ca.com
<ul style="list-style-type: none"> – HMO / PPO 	888.888.8288	
<ul style="list-style-type: none"> – HDHP 	866.207.9878	
<ul style="list-style-type: none"> Wells Fargo (HSA Plan) 	866.890.8309	www.wellsfargo.com/hsa
Pharmacy		
<ul style="list-style-type: none"> US Script 	866.264.4161	www.usscript.com
Dental		
<ul style="list-style-type: none"> Transwestern Dental 	559.499.2000	www.trans-western.com
Vision		
<ul style="list-style-type: none"> MES Vision 	877.601.9083	www.mesvision.com
Employee Assistance Program		
<ul style="list-style-type: none"> Insight 1348 W. Herndon Ave., Suite 101, Fresno, CA 93711 	559.226.7437	www.insighteap.com
Life Insurance		
<ul style="list-style-type: none"> Standard 	800.628.8600	www.standard.com
Deferred Compensation and Vantage Care Plans		
<ul style="list-style-type: none"> ICMA (Patricia Chavez, Retirement Plan Specialist) 	866.749.5176	www.icmarc.org
CalPERS	888.225.7377	www.calpers.ca.gov
Social Security	N/A	www.socialsecurity.gov
Internal Revenue Service	N/A	www.irs.gov
State of CA Employment Development Department (EDD)	N/A	www.edd.ca.gov



Innovative Solutions. Enduring Principles.

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Rancho Cordova, CA 95670
916.858.2981
License No. 0451271
keenan.com