2018

EMPLOYEE BENEFITS OVERVIEW

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What's Inside

Dear Valued Employee:

The City of San Bernardino is pleased to offer you a complete package of valuable benefits and programs to help you pay health care expenses, build capital for the future and provide financial security for your family. These benefits are an important element of your total compensation as a valuable employee of the City of San Bernardino. Furthermore, the entire cost of several benefits are paid for you.

2018 Offerings:

- **CSAC-EIA Kaiser Permanente Medical HMO**
- **CSAC-EIA Anthem Medical HMO (2 options)**
- **CSAC-EIA Anthem PPO**
- **DeltaCare Dental HMO**
- **CSAC-EIA Delta Dental PPO (2 options)**
- **EyeMed Vision (2 options)**
- **Mutual of Omaha Basic Life and AD&D**
- **Mutual of Omaha Voluntary Life and AD&D**
- **Mutual of Omaha Short Term Disability (STD)**
- **Mutual of Omaha Long Term Disability (LTD)**
- **Colonial Life Accident**
- **Colonial Life Critical Illness & Cancer**

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 pages 24-25 for more details.

IMPORTANT NOTICE

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

MEDICAL PLAN BENEFIT UPDATES

IMPORTANT: PLEASE READ

Currently, the City of San Bernardino offers medical benefits by contracting directly with the carriers, i.e., Aetna and Kaiser. Effective January 1, 2018, the City of San Bernardino will be offering medical benefits with Anthem and Kaiser through California State Association of Counties Excessive Insurance Authority (CSAC EIA).

The current benefit administrator, Benefit Coordinators Corporation (BCC), will remain the administrator on the new CSAC EIA Medical plans.

Kaiser Members – No plan changes, no group number change, no new ID card. If no changes are being made, no action is required.

All members on the current Aetna plans will be receiving a termination letter in the mail. This is a formality for the termination of the current group plans.

Aetna HMO Members – Effective January 1, 2018 City of San Bernardino will be offering HMO medical benefits through Anthem. All employees enrolled in an Aetna HMO plan are urged to contact BCC Customer Service during open enrollment to re-enroll in the new Anthem plan and select your PCP, Primary Care Physician. If you do not contact BCC, you will be mapped from your current Aetna HMO plan into the corresponding new Anthem plan and your PCP will be auto assigned by Anthem. Once you receive your new ID card from Anthem, you can contact their Customer Service Department and select a new PCP.

Aetna Open Access Managed Choice POS Members – Effective January 1, 2018 City of San Bernardino will be offering PPO medical benefits through Anthem. All employees enrolled in an Aetna Open Access Managed Choice POS plan are urged to contact BCC Customer Service during open enrollment to re-enroll in the new Anthem PPO medical plan. If you do not contact BCC, your current medical coverage will be mapped from your current Aetna Open Access Managed Choice POS plan into the new Anthem PPO plan.

> ***PPO Members – Will receive an additional ID card from Express Scripts. This identification card will need to be presented at the retail Pharmacy when obtaining prescriptions. The Anthem medical card states "No Pharmacy" and if the Anthem medical ID card is presented at the pharmacy, you will be told you do not have prescription benefits. Express Scripts uses Accredo Health for their Specialty Medication distribution.***

Mail Order Prescription

During the transition from the current programs to the CSAC EIA programs, it is strongly advised all individuals using the mail order prescription program fill your current prescription to assure you have enough medication to last through February.

The new CSAC EIA program will require all mail order participants to provide a new prescription for the mail order program in December, to be processed in January of 2018. Your welcome kit from the new pharmacy program, Express Scripts, will contain a prescription mail order form.

OPEN ENROLLMENT

Open Enrollment is your once-a-year opportunity to elect, change or cancel your benefits coverage, or add/ drop dependent coverage. Here is some important information regarding this year's open enrollment:

Please consider your options carefully because you may only make changes to your benefit elections during open enrollment, or if you experience a mid-year "qualified status change" (see Page 6).

All benefit changes will be effective January 1, 2018.

Open Enrollment Dates:

The open enrollment period is from October 23 - November 3, 2017. All enrollments must be completed in the Benefit Coordinators Corporation (BCC) system prior to November 3 at 3:00p.m. (PST). If you have any questions or require assistance with your enrollment, please contact BCC Customer Service at 855-230-0745, Ext 6414.

It is recommended that all employees verify their information in the BCC system even if they are not making any changes. Please see Page 7 for further instructions on using the BCC on-line system or accessing Customer Service for assistance.

Key Points to Keep In Mind

- Employees currently enrolled in the Flexible Spending Account (FSA), must re-enroll for the 2018 plan year. FSA enrollment does not automatically roll over to the new plan year.
- The Social Security Number field is mandatory for employees and dependents.
- If you are currently enrolled in the Kaiser Medical plan and do not make any changes, you will automatically be enrolled in your current benefits for the 2018 plan year.
- If you are currently enrolled in an Aetna Medical plan and do not go on the BCC site and enroll in a new Anthem Medical plan, you will automatically be mapped from your current Aetna Plan into the new Anthem corresponding plan.
- If you do not make any changes to your dental or vision benefits, you will automatically be enrolled in your current benefits for the 2018 plan year.

The City offers a pro-rated health insurance waiver stipend for employees meeting eligibility requirements. **Please see Page 9 for further details.**

ELIGIBILITY FOR BENEFITS

Employee Eligibility

You are eligible for our benefit program if you are a regular full-time employee. You may enroll your dependents in some of the benefits. Please see your Employee Benefit Materials to learn more about your coverage.

When Coverage Begins

As a new employee, your benefits become effective on the first of the month following date of hire.

In order to comply with the Affordable Care Act (ACA), the City of San Bernardino generally determines your eligibility for benefits based using the Look-Back Measurement Method. Refer to the Look-Back Measurement Method section of this guide for additional information on how your eligibility is determined.

Please Note: It is the responsibility of the employee to enroll in the plan prior to completion of the eligibility period. Any employee that declines coverage as a new hire will not have the option to enroll again until open enrollment held annually in the Fall unless the employee experiences a qualified status change.

Dependent Eligibility

- Your legal spouse
- Your domestic partner (must be registered with the California State Registry) A copy must be provided to the Human Resources Department.
- Your or your domestic partner's natural children, stepchildren, adopted children and/or children of which the employee or domestic partner is the legal guardian. In addition, dependent children must meet the following age requirements:
  - ⇒ Dependents are eligible up to age 26 for medical, dental, and vision coverage.
- Your physically or mentally handicapped children who meet the plan eligibility guidelines and depend on you for support, regardless of age.

NOTE: Effective January 1, 2018 grandchildren are no longer eligible on the CSAC EIA Kaiser plan.

RULES FOR BENEFIT CHANGES DURING THE YEAR

Other than during annual open enrollment, you may only make changes to your benefit elections if you experience a qualified status change or qualify for a "special enrollment". If you qualify for a mid-year benefit change, you may be required to submit proof of the change or evidence of prior coverage.

Qualified Status Changes include:

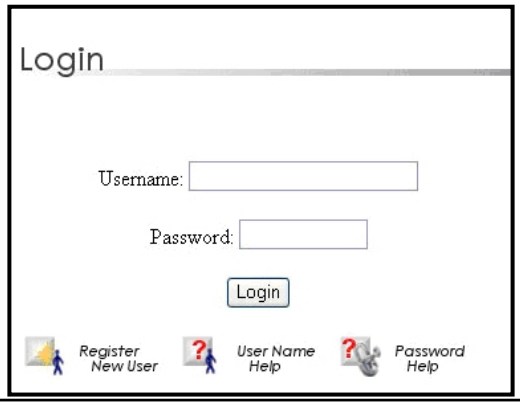
- **Change in legal marital status**, including marriage, divorce, legal separation, annulment, and death of a spouse
- **Change in number of dependents**, including birth, adoption, placement for adoption, or death of a dependent child
- **Change in employment status that affects benefit eligibility**, including the start or termination of employment by you, your spouse, or your dependent child; or a change in your Bargaining Unit
- **Change in work schedule**, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits
- **Change in a child's dependent status**, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- **Change in place of residence or worksite**, including a change that affects the accessibility of network providers
- **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.
- **An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA)** including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan**.**

Two (2) rules apply to making changes to your benefits during the year:

- **Any changes you make must be consistent with the change in status, AND**
- **You must make the changes within 30 calendar days of the date the *event* (marriage, birth, etc.) occurs (unless otherwise noted above).**

HOW TO ENROLL IN BENEFITS

STEP 1 LOGIN

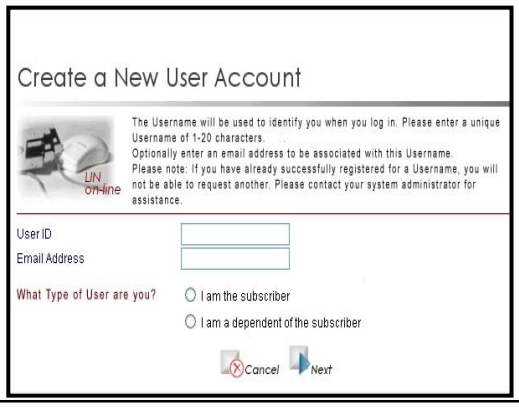


Login

Please Note: All passwords will be re-set for the 2018 Open Enrollment. Everyone will be required to create a new password.

- Log onto https://www.benxcel.com/**ctysb.htm**
- Click "Register New User" on Login Screen

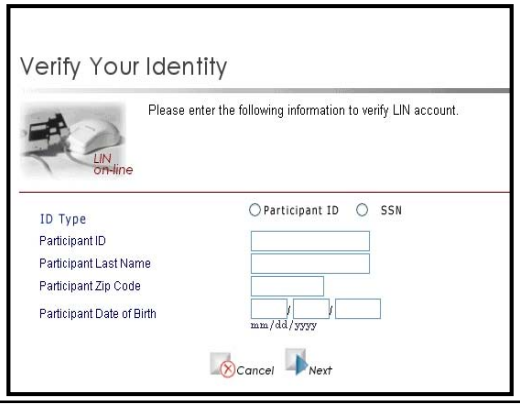
STEP 2 CREATE AN ACCOUNT



Set Up User ID & Password

- Enter a Unique User ID of 1-20 characters
- Enter a valid email address to be associated with the chosen ID
- Choose the option that applies to you: a.) "I am the insurance subscriber" or b.) "I am a dependent of the subscriber"
- Click "Next"

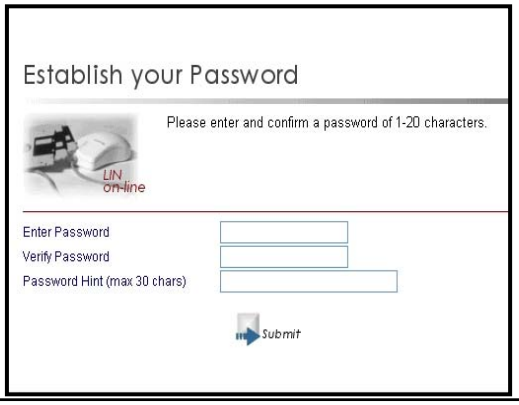
STEP 3 VERIFICATION



Set Up Account Verification

- Select your preferred ID type, either "Participant ID" or "SSN"
- Type your Participant ID with the chosen ID
- Type your last name in **ALL CAPITAL LETTERS**
- Type your Zip Code
- Include your date of birth in mm/dd/yyyy format
- Click "Next"

STEP 4 CREATE A PASSWORD



Establish Your Password

- Create a password and verify your choice in the next box
- Password hint might be your mother's birth date or your dog's name, etc
- Click "Submit" and you will be taken to the Enrollment section

OR CALL CUSTOMER SERVICE AT (855) 230-0745, Ext 6414 FOR ASSISTANCE

BENEFITS AT A GLANCE

Benefits	Who Pays	When Benefit Begins	When Benefit Ends
Medical	You and the City of San Bernardino	First day of the month following date of hire (must enroll within 30 days of hire)	Last day of the month in which you terminate employment or a qualifying event occurs
Dental			
Vision			
Basic Life Insurance	The City of San Bernardino	First day of the month following date of hire (must enroll within 30 days of hire)	Last day of employment
Accidental Death & Dismemberment Insurance			
Supplemental Life and AD&D Insurance	You and/or the City of San Bernardino	First day of the month following date of hire (must enroll within 30 days of hire)	Last day of employment
Short Term Disability	The City of San Bernardino	First day of the month following date of hire (must enroll within 30 days of hire)	Last day of employment
Long Term Disability			
Colonial Life Accident and Critical Illness & Cancer (Employee Elected Optional Benefit)	You	Contact the Human Resources Department for further information	
Flexible Spending Account	You	First day of the month following date of hire (must enroll within 30 days of hire)	Last day of the month in which you terminate employment or a qualifying event occurs
Employee Assistance Program	The City of San Bernardino	First day of employment	Last day of employment

EMPLOYEE CONTRIBUTIONS

Employer contributions for medical, dental, and vision insurance benefits are based on the medical coverage elected by the employee. If an employee elects employee only medical coverage, then the employee only contribution is given to the employee. There is, however, a contribution that pertains to ancillary only elections such as dental, vision and/or supplemental life and AD&D. If ancillary benefits only are elected without medical, the employee only contribution will apply in all circumstances for all bargaining units, except EDA. If an employee elects employee only medical coverage; but chooses to elect full family dental and vision coverage, the employee will still receive the employee only contribution towards dental and vision. Employer contributions may be used to pay for Mutual of Omaha Voluntary life benefits; however, the employer contributions do not apply to the employee elected optional Colonial Life products. Premiums for the Colonial Life products will be payroll deducted.

Any contributions not utilized by an employee shall revert to the City, unless otherwise provided for in an Agreement with a Bargaining Unit.

Please contact Human Resources Department for information regarding specific City contribution amounts toward employee health plan benefits.

HEALTH INSURANCE WAIVER STIPEND POLICY

Program Description

The City of San Bernardino agrees to provide full-time eligible employees who waive health benefits an annual "*Health Insurance Waiver Stipend*". Please contact Human Resources Department for further details.

Eligibility Requirements

- Employees must be regular full-time and be in paid status for a minimum of 21 hours per week to be eligible for the benefit. Paid status includes hours paid for regular work time, vacation leave, sick leave, compensatory time off, jury duty leave, administrative leave, military leave, disciplinary, paid holidays, MOU concession leave, and carpool leave. For members of Safety groups, also included is "4850" paid injury leave. It does not include amounts paid by any other disability benefit.
- Employees must provide the City's Human Resources Department with satisfactory proof (written) of medical insurance coverage comparable to the City's medical insurance plan.
- Employees participating in this plan are required to waive all medical, dental, vision, supplemental life, and supplemental AD&D benefits.
- Employees will continue to be eligible for the following City defined plans as outlined in their current MOU:

  Basic Life Insurance
  Basic AD&D
  Short or Long Term Disability

Health Insurance Waiver Stipend

- Eligible employees shall receive the first payday in December (December 15th).
- Employees must be employed through the end of the last payroll period in November to qualify for this benefit.
- Unless hired during the benefit year, employees must participate in the program for the full 12 months in order to receive the full stipend. Employees on payroll on November 30th who were hired during the benefit year and did not work the entire 12-month period shall earn the stipend on a pro-rata basis. **Employees who waived insurance benefits during open enrollment, but then requested to enroll in benefits prior to November 30th will not be eligible for any portion of the stipend.**
- Employees who elect to drop coverage midyear are not eligible to participate in the stipend program.

Please note that if you do not complete and sign the waiver form prior to the end of open enrollment, you will not be eligible for the stipend.

The *Health Insurance Waiver Stipend* is not considered compensation for purposes of CalPERS and is subject to state and federal taxes. Earnings will be reported on the employees' W-2 form each year.

Processing

- Employees will have the opportunity to enroll in the program during the Open Enrollment period for health benefits each year. The enrollment process requires employees to sign the waiver of benefits and release agreement form.
- By December 5th of each year, the Human Resources Department will provide the Finance Department with a list of those employees approved to receive the stipend on their December 15th paycheck.

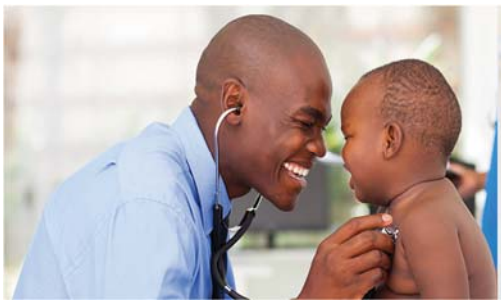
PREMIUM COSTS

MEDICAL	
CSAC-EIA Anthem HMO (Select Network)	**Cost**
Employee Only	$553.00
Employee + 1	$1,085.00
Employee + Family	$1,452.00
CSAC-EIA Anthem HMO (Full Network)	**Cost**
Employee Only	$634.00
Employee + 1	$1,243.00
Employee + Family	$1,664.00
CSAC-EIA Anthem PPO	**Cost**
Employee Only	$954.00
Employee + 1	$1,872.00
Employee + Family	$2,505.00
CSAC-EIA Kaiser HMO	**Cost**
Employee Only	$615.00
Employee + 1	$1,207.00
Employee + Family	$1,615.00
DENTAL	
DeltaCare Dental HMO	**Cost**
Employee Only	$17.89
Employee + 1	$29.56
Employee + Family	$44.03

DENTAL	
CSAC-EIA Delta Dental PPO Core	**Cost**
Employee Only	$31.20
Employee + 1	$67.40
Employee + Family	$92.10
CSAC-EIA Delta Dental PPO Buy-Up	**Cost**
Employee Only	$38.50
Employee + 1	$83.80
Employee + Family	$114.70
VISION	
EyeMed Vision Base	**Cost**
Employee Only	$6.13
Employee + 1	$11.58
Employee + Family	$16.96
EyeMed Vision Buy-Up	**Cost**
Employee Only	$6.95
Employee + 1	$13.14
Employee + Family	$19.25

Pre-tax Deductions
Your medical, dental, and vision contributions will be made through payroll deductions and paid on a pre-tax basis. That is, you do not pay taxes on the portion of your income that goes toward your benefit contributions. If you do not want your contributions deducted on a pre-tax basis, please notify the Human Resources Department as soon as possible.

MEDICAL PLAN BENEFIT OPTIONS



Kaiser Permanente Health Maintenance Organization (HMO) Plan: The HMO plan offers comprehensive coverage and a broad network of physicians and hospitals to choose from. Care is coordinated through each member's Primary Care Physician (PCP). The plan has the convenience of scheduled copays for specific procedures and no deductibles.

KAISER PERMANENTE	HMO
Calendar Year Deductible	None
Calendar Year Out-of-Pocket Maximum (Individual / Family)	$1,500 / $3,000
Physician Care	
Primary Physician Office Visit	$20 / Visit
Specialist Office Visit	$20 / Visit
Preventive Care	No copay
Lab and X-Ray	No copay
MRI, CT and PET	No copay
Chiropractic (up to 20 visits per calendar year)	$15 / Visit
Hospital Care	
Urgent Care	$20 / Visit
Emergency Room	$50 / Visit (waived if admitted)
Inpatient	No copay
Outpatient	$20 / Procedure
Prescription Drugs	Generic / Brand
Retail Participating Pharmacy (up to a 30 day supply)	$10 / $30
Mail Order (up to a 100 day supply)	$20 / $60

MEDICAL PLAN BENEFIT OPTIONS

Anthem Health Maintenance Organization (HMO) Plans: The Anthem HMO plans offer comprehensive coverage and a broad network of physicians and hospitals to choose from. Care is coordinated through each member's primary care physician (PCP). The plans have the convenience of scheduled copays for specific procedures and no deductibles to satisfy. The Select Network HMO plan offers a slightly smaller network of providers to choose from and higher copays, but lower monthly premiums. The Full Network HMO plan offers the complete network of providers but higher monthly premiums.

ANTHEM	HMO (Select Network)	HMO (Full Network)
Calendar Year Deductible	None	None
Calendar Year Out-of-Pocket Maximum (Individual / Family)	$2,000 / $4,000	$1,500 / $3,000
Physician Care		
Primary Physician Office Visit	$20 / Visit	$20 / Visit
Specialist Office Visit	$40 / Visit	$20 / Visit
Preventive Care	No copay	No copay
Lab and X-Ray	No copay	No copay
MRI, CT and PET	$100 / Visit	No copay
Chiropractic (up to 30 visits per calendar year)	$10 / Visit	$10 / Visit
Hospital Care		
Urgent Care	$20 / Visit	$20 / Visit
Emergency Room	$100 / Visit (waived if admitted)	$50 / Visit (waived if admitted)
Inpatient	$250 / Admit	No copay
Outpatient	$125 / Visit	No copay
Prescription Drugs	**Tier 1a / Tier 1b / Tier 2[1] / Tier 3[1]**	
Rx Copay Out-of-Pocket Maximum	Combines with medical	Combines with medical
Retail Participating Pharmacy (up to a 30 day supply)	$5 / $20 / $30 / $50	$5 / $15 / $25 / $45
Mail Order (up to a 90 day supply)	$12.50 / $50 / $90 / $150	$12.50 / $37.50 / $75 / $135

1. If a member requests a Tier 2 or Tier 3 drug when a Tier 1 drug version exists, the member pays the Tier 1 drug copay plus the difference in cost between the prescription drug maximum allowed charge for the Tier 1 drug and the Tier 2 or Tier 3 drug, unless the physician indicates "dispense as written" on the prescription.

NOTE: Benefits in red are changes from 2017.

MEDICAL PLAN BENEFIT OPTIONS

Anthem Preferred Provider Organization (PPO) Plan: The Anthem PPO plan provides choice and flexibility. Participants can choose an in-network provider or go to an out-of-network provider at a higher cost. There are annual deductibles before benefits apply and you are responsible for copays and co-insurance. Service from Non-Network providers may have lower benefits and be subject to balance billing.

ANTHEM	PPO	
	In-Network	Out-Of-Network
Calendar Year Deductible (Individual / Family)	$500 / $1,000	
Calendar Year Out-of-Pocket Maximum (Individual / Family)	$2,000 / $4,000	
Physician Care		
Primary Physician Office Visit	$20/ Visit[1]	40%
Specialist Office Visit	$20/ Visit[1]	40%
Preventive Care	No Charge[1]	40%
Lab and X-Ray	10%	40%
MRI, CT and PET	10%	40%
Chiropractic (up to 24 visits per calendar year)	10%	40%
Hospital Care		
Urgent Care	$20/ Visit[1]	40%
Emergency Room	$50 copay + 10% (copay waived if admitted)	
Inpatient	10%	40%
Outpatient Surgery	10%	40%
Prescription Drugs	**Tier 1 / Tier 2[2] / Tier 3[2]**	
Rx Copay Out-of-Pocket Maximum	$5,350 / $10,700	$5,350 / $10,700
Retail Participating Pharmacy (up to a 30 day supply)	$10/ $20 / $35	Member pays the retail pharmacy copay plus 40% of the submitted cost.
Mail Order (up to a 90 day supply)	$15 / $30 / $50	Not Covered

1. Deductible waived.
2. If you purchase a brand-name medication when a generic medication is available, you will pay the generic copayment, plus the difference in cost between the brand and the generic.

DENTAL PLAN BENEFIT OPTIONS

DeltaCare Dental Health Maintenance Organization (HMO) Plan: The HMO has a large prepaid dental network. The plan works like the medical HMO and care is coordinated through an assigned primary care provider. The plan offers the convenience of scheduled copays for specific procedures with no deductible or annual maximum.

DELTA DENTAL	DeltaCare HMO In-Network (only)
Calendar Year Deductible	None
Maximum Annual Benefit	Unlimited
Preventive Services Oral Exams Cleaning every 6 months X-rays Sealants Fluoride treatment	$0-$45; Refer to Patient Charge Schedule for applicable copay
Basic Services Fillings Routine Extractions Oral Surgery Endodontics Periodontics	$0-$280; Refer to Patient Charge Schedule for applicable copay
Major Services Surgical Extractions Bridgework Dentures Crowns	$0-$240; Refer to Patient Charge Schedule for applicable copay
Orthodontia Child (to age 19) Adult	$1,700 $1,900

DENTAL PLAN BENEFIT OPTIONS

CSAC-EIA Delta Dental Preferred Provider Organization (PPO) Plans: The Dental PPO Plans provide you with the ability to visit any dentist in the Delta Dental network making your costs significantly reduced by obtaining your dental care from the Preferred Providers (in-network dentists) over the Non-Preferred Providers (out-of-network providers).

DELTA DENTAL	CSAC-EIA Delta Dental PPO		CSAC-EIA Delta Dental PPO Buy Up Option	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Calendar Year Deductible	$50 (per person)		$50 (per person)	
Maximum Annual Benefit	$1,000		$2,000	
Preventive Services[1] Oral Exams Cleaning every 6 months X-rays Sealants Fluoride treatment	100%	80%	100%	80%
Basic Services Fillings Routine Extractions Oral Surgery Endodontics Periodontics	80%	80%	80%	80%
Major Services Surgical Extractions Bridgework Dentures Crowns	50%	50%	50%	50%
Orthodontia Child (to age 18) Adult	80% ($2,000 lifetime per person)	80% ($2,000 lifetime per person)	80% ($2,000 lifetime per person)	80% ($2,000 lifetime per person)

[1] Deductible is waived for Diagnostic and Preventive services.

VISION PLAN BENEFIT OPTIONS

EyeMed Vision: The vision plans provide participants with access to a large network of vision care providers and offers valuable vision benefits including exams, frames, lenses, and/or contact lenses. The plan allows you to see any provider of choice; however, you will pay less out of pocket if you see an in-network provider.

EYEMED VISION	Base		Buy Up	
Plan Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Exam: *(once every 12 months)*	$10 copay	Up to $49 Allowance	$10 copay	Up to $49 Allowance
Standard Lenses: *(once every 12 months)*				
• Single	$10 copay	Up to $35 Allowance	$10 copay	Up to $35 Allowance
• Bifocal	$10 copay	Up to $49 Allowance	$10 copay	Up to $49 Allowance
• Trifocal	$10 copay	Up to $74 Allowance	$10 copay	Up to $74 Allowance
Frame: *(once every 12 months)*	Up to $130 Allowance + 20% Off Retail Price Over $130	Up to $60 Allowance	Up to $150 Allowance + 20% Off Retail Price Over $150	Up to $75 Allowance
Contact Lenses *(in lieu of eyeglasses, once every 12 months)*				
Fit and Follow-up Visits	Up to $55	Not applicable	Up to $55	Not applicable
Materials only:				
• Elective Conventional	Up to $130 Allowance + 15% Off Retail Price Over $130	Up to $104 Allowance	Up to $150 Allowance + 15% Off Retail Price Over $150	Up to $120 Allowance
• Elective Disposables	Up to $130 Allowance	Up to $104 Allowance	Up to $150 Allowance	Up to $120 Allowance
• Medically Necessary	No charge	Up to $200 Allowance	No charge	Up to $200 Allowance

Benefits are based on a 12 month service year, not a calendar year. This means that you are not eligible for another exam or new lenses or contacts until at least 12 months have passed since you last received services. You are not eligible for new frames until 12 months have passed from the last date of service.

EMPLOYEE ASSISTANCE PROGRAM

The City's Employee Assistance Program (EAP) benefit is offered through The Counseling Team International (TCTI). Just when you think you have it figured out, along comes a challenge. But whether those challenges are big or small, your EAP is available to help you and your family find a solution and restore your peace of mind. The EAP provides face to face visits and can refer you to professional counselors and services that can help you resolve emotional health, family and work related issues. Assistance is available 24-hours a day.

You can call TCTI or go online, search the provider directory and request a referral.

Call to get the assistance you need to help resolve life's challenges:

(800) 222-9691

Or visit the website at www.thecounselingteam.com

This insurance coverage is provided at no charge to the employee.

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Life and Accidental Death & Dismemberment insurance is an important part of your comprehensive benefits package. For peace of mind and the financial protection for you and your family in the event of death or a serious accident, all benefit eligible employees are automatically enrolled in the Basic Life and Accidental Death & Dismemberment Insurance Program administered through Mutual of Omaha. Basic life insurance is also available for your spouse and children. Refer to your Bargaining Unit's MOU for the exact amount provided.

This insurance coverage is provided at no charge to the employee.

VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

You may purchase additional Voluntary Life and Accidental Death & Dismemberment coverage for yourself through Mutual of Omaha. The Voluntary Life minimum benefit is the greater of 1x annual salary or $10,000 to a maximum of 4x annual salary up to $500,000 and is purchased in increments of 1x annual salary.

Voluntary Accidental Death & Dismemberment can be purchased in amounts of $25,000; $50,000; $75,000; $100,000; $150,000; $200,000; or $250,000.

The Voluntary Life and Accidental Death & Dismemberment benefits can be purchased separately or combined.

Premiums will be deducted from your paycheck.

NOTE: Age and salary are based on effective date and will increase at anniversary (January 1) thereafter.

SHORT TERM DISABILITY (STD)

All active eligible employees are covered under the Short Term Disability (STD) plan through Mutual of Omaha. The STD plan provides you with income replacement when non-work related illness or injury makes it impossible for you to work for a short period of time. STD income benefit will be reduced by other deductible sources of income.

This insurance coverage is provided at no charge to the active eligible employees listed below.

Classification	Management, Middle Management, Confidential, Police Management, Elected Officials (except Council Members)
Weekly Benefit Amount	60% of before-tax earnings
Maximum Weekly Benefit	$1,250
Benefits Begin	61st day of disability
Maximum Payment Period	Up to 17 weeks

LONG TERM DISABILITY (LTD)

All active eligible employees are covered under the Long Term Disability (LTD) plan through Mutual of Omaha. The LTD plan provides you with income replacement when non-work related illness or injury make it impossible for you to work for an extended period of time. The benefit is reduced by other deductible sources of income. The age at which the disability begins may affect the duration of the benefits.

This insurance coverage is provided at no charge to the active eligible employees listed below.

Classification	Management, Police Management, Middle Management, Confidential, Elected Officials (except City Council)	General Unit
Monthly Benefit Amount	60% of before-tax earnings	50% of before tax earnings
Maximum Monthly Benefit	$5,000	$5,000
Benefits Begin	180th day of disability	90th day of disability
Maximum Payment Period	Social Security Normal Retirement Age	

COLONIAL LIFE VOLUNTARY PRODUCTS

Colonial Life products provide coverage for you, your spouse, and eligible dependent children (with most plans). Benefits will be paid directly to you, unless you specify otherwise. You may receive benefits regardless of any other insurance you may have with other insurance companies (with most plans). All benefits are offered post-tax and are deducted from each paycheck.

Accident Insurance

This plan helps offset unexpected medical expenses, such as emergency room fees, deductibles and co-payments that can result from fracture, dislocation or other covered accidental injury.

Critical Illness and Cancer Insurance

Critical Illness insurance supplements your major medical coverage by providing a lump-sum benefit you can use to pay the direct and indirect costs related to a covered critical illness or covered cancer diagnosis, which can often be expensive and lengthy. Examples of covered illnesses include heart attack, stroke, major organ failure, coma and blindness. The plan also includes a benefit for the extended treatment of cancer.

Colonial life is extending the Guarantee Issue (GI) for existing policyholders (under the current GI level) and new enrollees (either new hires or employees never previously enrolled). Guarantee Issue is up to $25,000 for Employee Face Amount. Spouse's and dependents' GI Face Amount is 50% of Employee Face Amount.

For new enrollments and policy changes (other than requests to cancel), please contact the Call Center at (877) 463-2060 Monday through Friday during the hours of 8:00 a.m. to 5:00p.m. Pacific Time. If you have other questions, please contact Customer Service at (800) 325-4368.

If you wish to cancel your current policy, you can contact the Customer Service number above for a Request for Service form or you can request the form from Human Resources.

FLEXIBLE SPENDING ACCOUNT (FSA)

Do you have out-of-pocket expenses for medical co-pays, deductibles, dental/vision expenses throughout the year? Do you have day care or elder care expenses?

A great way to save money over the course of a year is by participating in the Flexible Spending Accounts (FSAs). These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts. Money from these accounts is then used to pay eligible medical and dependent care expenses.

Pre-tax means the dollars you use for eligible expenses are not subject to social security tax, federal income tax and, in most cases, state and local taxes. Money you would have normally paid in taxes, can now be used to pay for your qualified medical and dependent care expenses.

You may enroll in the City of San Bernardino FSA sponsored plan even if you receive health care insurance through your spouse's employer. In addition, the FSA can be used for eligible expenses for all of your qualified dependents.

Health Care Spending Account

This account will reimburse you with pre-tax dollars for health care expenses not reimbursed under your family's health care plans. **You can elect to contribute up to $2,000 maximum annually for the Health Care Reimbursement Account.**

Dependent Care Spending Account

This account will reimburse you with pre-tax dollars for day care expenses for your child**(ren)** and other qualifying dependents. **The maximum amount you may contribute to a Dependent Care Spending Account is $5,000 a year or $2,500 if you are married and file separate tax returns.**

Eligible Dependents for Dependent Care Spending Accounts Include:

- Children under the age of 13 who you have primary custody of; and
- Children or other dependents of any age who are physically or mentally unable to care for themselves and who qualify. You may use the federal childcare tax credit and the Dependent Care Spending Account; however, your federal credit will be offset by any amount deferred into dependent care plan.

How Your FSA Works

Each year during the Open Enrollment period, you decide how much you want to contribute to the Healthcare and Dependent Care Spending Accounts. Each pay period, the money is deducted before taxes, in equal increments, from your pay and contributed to your healthcare and / or dependent care spending account(s).

Be Cautious!!

- Only qualifying medical and dependent care expenses incurred during the plan year will be eligible for reimbursement. You may incur eligible expenses from January 1, 2018 through December 31, 2018.
- **Use it or lose it!** Money in the accounts must be claimed within 90 days after the end of the plan year or it will be subject to the "use-it-or-lose it" rule and will be forfeited.
- Once you enroll, you can only change your elected payroll deduction if there is a change in family status, such as: Marriage, Divorce, Death, Birth, Adoption, or Change in Employment Status.
- Money cannot be transferred between the Health Care and Dependent Care FSA.
- If you are no longer working for the City of San Bernardino, you can continue to submit requests for expenses incurred up to and including your date of separation, up to 90 days after your date of separation, unless you elect COBRA for a Health Care FSA.

BEN-IQ MOBILE APPLICATION

Check out Ben-IQ and experience benefits at the Speed of Life

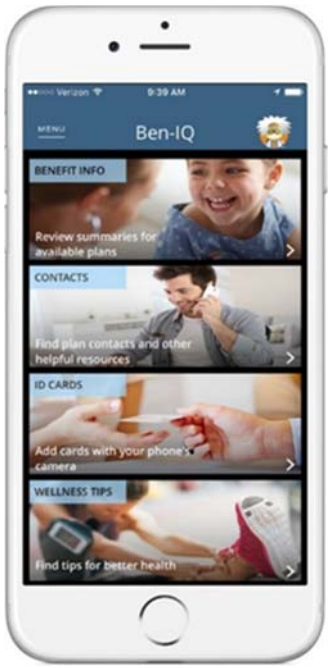
This complimentary application available to all smart phone users allows you to have 24/7 access to your health plan highlights, nurse line and other important phone numbers as well as wellness tips.

To download Ben-IQ :

1. Go to you app store (Ben-IQ is supported by both iPhone and Android platforms)
2. Search for "**Ben-IQ**"
3. Install & Launch the application
4. Enter the password "**CTYSB**" to access your information
5. Accept the "**Terms and Conditions**"

Once downloaded, open up the app any time you need plan information,
such as:

- Your copays and deductibles
- Your NurseLine number
- You insurance company's number
- Definitions of healthcare terms
- Need to find an in-network provider right away? Ben-IQ can help with that too



AVAILABILITY OF SUMMARY INFORMATION

As an employee, the health benefits provided by the City of San Bernardino represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The City of San Bernardino offers a variety of benefit plans to eligible employees. The federal healthcare reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by the City of San Bernardino are available by contacting your Human Resources/Benefits Department.

REQUIRED FEDERAL NOTICES

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for the City of San Bernardino describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Human Resources.

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. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act Notice

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 Human Resources at (909) 384-5337 and/or (909) 384-5161.

NOTICE OF CHOICE OF PROVIDERS

The Anthem HMO plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Anthem 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 insurance carrier directly.

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

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

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in a City of San Bernardino health plan for 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 a City of San Bernardino health plan without waiting for the next open enrollment period if you:

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

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the City of San Bernardino's medical plan if your dependent becomes 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 NOTICE FROM CITY OF SAN BERNARDINO 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 San Bernardino 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 San Bernardino has determined that the prescription drug coverage offered by Anthem Blue Cross and Kaiser Permanente medical plans 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 through 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 Bernardino 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 the City of San Bernardino is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with the City of San Bernardino 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.

(continued)

IMPORTANT NOTICE FROM CITY OF SAN BERNARDINO ABOUT YOUR PRESCRIPTION DRUG COVERAGE *AND* MEDICARE

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may increase 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. You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of San Bernardino 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 www.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 www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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, 2018
Name of Entity:	City of San Bernardino
Contact:	Human Resources Department
Address:	290 North "D" Street San Bernardino, CA 92401
Phone Number:	(909) 384-5337 (909) 384-5161

LOOK-BACK MEASUREMENT METHOD

You and your dependents are eligible for the medical plan if you are a full-time employee. A full-time employee is generally an employee who works on average 130 hours per month, as defined by the ACA. Hours that count toward full-time status include each hour for which an employee is paid or entitled to payment for the performance of duties for the employer, and each hour for which an employee is paid or entitled to payment for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. ACA full-time status can affect or determine medical benefits eligibility but is not a guarantee of benefits eligibility. The City of San Bernardino uses the Look-Back Measurement Method to determine whether an employee meets this eligibility threshold.

NEW EMPLOYEES

New employees hired to work full-time
If you are hired as a new full-time employee (work on average 130 or more hours a month), you and your dependents are generally eligible for Anthem or Kaiser's health plan coverage as of the 1st day of the month following date of hire.

New employees hired to work a variable hour or seasonal schedule
If you are hired into a part-time position, a position where your hours vary and the City of San Bernardino is unable to determine — as of your date of hire — whether you will be a full-time employee (work on average 130 or more hours a month), or you are hired as a seasonal employee who will work for six (6) consecutive months or less (regardless of monthly hours worked), you will be placed in an initial measurement period (IMP) of 12 months to determine whether you are a full-time employee.

Your 12-month IMP will begin on the first of the month following your date of hire and will last for 12 months. If, during your IMP, you average 30 or more hours a week over that 12-month period, you will be full time and, if otherwise eligible for benefits, you will be offered coverage by the first of the month after your IMP ends.

Your full-time status will remain in effect during an associated stability period that will last 12 months from the date that status is determined. If your employment is terminated during that stability period, and you were enrolled in benefits, you will be offered coverage under COBRA.

ONGOING EMPLOYEES

The City of San Bernardino uses the look-back measurement method to determine Anthem and Kaiser's group health plan eligibility for ongoing employees. An ongoing employee is an individual who has been employed for an entire standard measurement period. A standard measurement period is the 12-month period of time over which the City of San Bernardino counts employee hours to determine which employees work full-time.

An employee is deemed full-time if he or she averages 130 or more hours a month over the 12-month standard measurement period. Those employees who average 130 or more hours a month over the 12-month standard measurement period will be full-time and, if otherwise eligible for benefits, offered coverage as of the first day of the stability period associated with the standard measurement period. Full-time status will be in effect for a 12-month stability period.

If your employment is terminated during a stability period, and you were enrolled in benefits, you will be offered continued coverage under COBRA.

The City of San Bernardino uses the standard measurement period and associated stability period annual cycle set forth below.

Measurement Period: Time to determine if you work 130+ hours per month on average – used to establish if you are "full-time" or "part-time" for medical eligibility	December 1 – November 30
Stability Period: Time during which you will be considered "full-time" or "part-time" for medical plan eligibility - based on hours worked during preceding Measurement Period	January 1 – December 31

NOTES

CONTACT INFORMATION

Below is a listing of the toll-free numbers you can call with questions about benefit coverage and providers in your area. You can also use the websites to access provider information as well as any additional discount programs available through each carrier.

Plan	Carrier	Policy Number	Telephone	Website
Medical	Kaiser HMO	227298	(800) 464-4000	www.kp.org
	Anthem HMO (Select and Full Network)	175075	(800) 967-3015	www.anthem.com/ca
	Anthem PPO	175075	(800) 967-3015	www.anthem.com/ca
	Express Scripts (PPO only)	RX4EIAH	(877) 554-3091	www.express-scripts.com
Dental	DeltaCare HMO	71573	(800) 422-4234	www.deltadentalins.com
	Delta Dental PPO	679	(800) 765-6003	www.deltadentalins.com
Vision	EyeMed Vision	9680190	(866) 723-0513	www.eyemedvisioncare.com
Life and AD&D LTD STD	Mutual of Omaha	GLUG-AQWQ GLTD-AQWQ GUG-AQWQ	(800) 775-8805 (life) (800) 877-5176 (disability)	www.mutualofomaha.com
Voluntary Accident & Critical Illness	Colonial Life	E4482949	800-325-4368	www.coloniallife.com
Employee Assistance Program (EAP)	The Counseling Team International	N/A	(800) 222-9691 (909) 884-0133	www.thecounselingteam.com
Flexible Spending Account (FSA) COBRA Administration Enrollment & Call Center for Active Employees	Benefit Coordinators Corporation (BCC)	NA	(855) 230-0745 Ext 6414	www.benxcel.com/CTYSB.htm
City of San Bernardino	Human Resources Department	N/A	(909) 384-5337 (909) 384-5161	www.sbcity.org
Deferred Compensation Section 457 Plan	Nationwide	0041573	(800) 769-4457	www.sbcity457.com

Employee Benefits Brochure designed and developed by

Alliant EMPLOYEE BENEFITS

in conjunction with the City of San Bernardino January 2018