



Management and Department Head Employees

City of Ontario 2015 Health Benefits Summary

Welcome to Open Enrollment for Plan Year 2015! This year's Open Enrollment period begins September 15th and ends October 10th. Open Enrollment offers you the opportunity to add or delete coverage, make changes to existing coverage and add or delete dependents. All changes made during Open Enrollment will be effective January 1, 2015.

Please visit www.ontariocityemployees.org. There you will find basic information on the Open Enrollment process, an overview of the benefit packages the City provides its employees and links to the various vendor and healthcare provider's websites which provide in depth information for all benefits and programs they offer.

ALL EMPLOYEES are required to login and verify benefits enrollment, even if no changes are made. Online enrollment/verification is through the City's third party administrator, Benefits Coordinator Corporation (BCC). For security purposes, on or after September 15th you will be required to log on as a "new user" **even if you have previously enrolled through BCC or currently have a Flexible Spending Account (FSA).**

ALL CHANGES AND VERIFICATIONS MUST BE COMPLETED BY THE END OF OPEN ENROLLMENT, OCTOBER 10, 2014.

The City contracts with CalPERS for medical coverage. CalPERS offers a choice of up to nine HMO plans. The plan options are two Anthem plans, two Health Net plans, two Blue Shield plans, United Healthcare, Sharp and Kaiser. All PPO plans are Anthem Blue Cross plans and include PERS Choice, PERS Select and PERSChoice and PORAC for safety members.

CalPERS has launched CalPERS|Compare, a one-stop-shop for your health information needs.

CalPERS|Compare is available to you now and lets you shop for medical services and prescriptions and compare your options. You can use it to track your past expenses and how much you should expect to pay. If you are enrolled in a CalPERS Anthem Blue Cross PERS Select, PERS Choice, or you can activate your CalPERS|Compare Account at <https://www.calperscompare.com>

Added new for all HMO plans for 2015 is a chiropractic and acupuncture benefit. Please review each plan for specific information and how to access this new benefit.

Dental plans are provided through Delta and your choices are Delta Care (DHMO), Delta DPO Basic and Delta DPO Buy-Up. Vision plans are through VSP and your choices are VSP Basic and VSP Buy-Up.

Items to consider when selecting medical, dental and vision:

- HMO or PPO plan?
- Deductibles and co-pay requirements?
- Selection of doctors?
- Frequency to replace glasses and contacts?
- Cost and flexibility of your plans?

If you have concerns regarding the quality or cost of your medical, dental and vision plans, this is the time to research other options available and/or contact Benefits. There may be a better available option for you.

All Open Enrollment information is available online and can be viewed, downloaded or printed at anytime. We have also scheduled Open Enrollment meetings at different locations throughout the Open Enrollment period. Please refer to the Meeting Schedule for dates, times and locations.

If you have any other questions, please email Benefits at benefits@ci.ontario.ca.us or you can reach us by phone at (909) 395-2433.

Getting onto Benxcel web inquiry tool is as easy as 1-2-3,4!

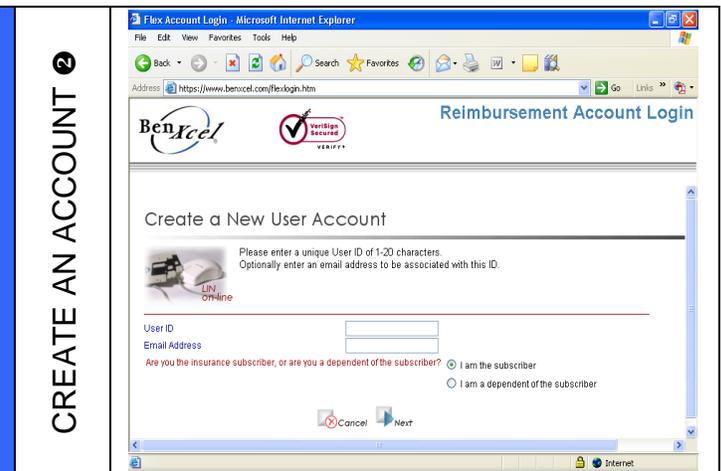
REMINDER: When enrolling or confirming your medical plan in the Benxcel system, medical plan rates and the health allotment provided to you by the City will not be displayed. This is due to the Zip Code eligibility rule and the regional pricing with the CalPERS medical plans. Please refer to your bargaining unit's Open Enrollment Brochure for medical plan rates and health allotments.



1
LOGIN

Login

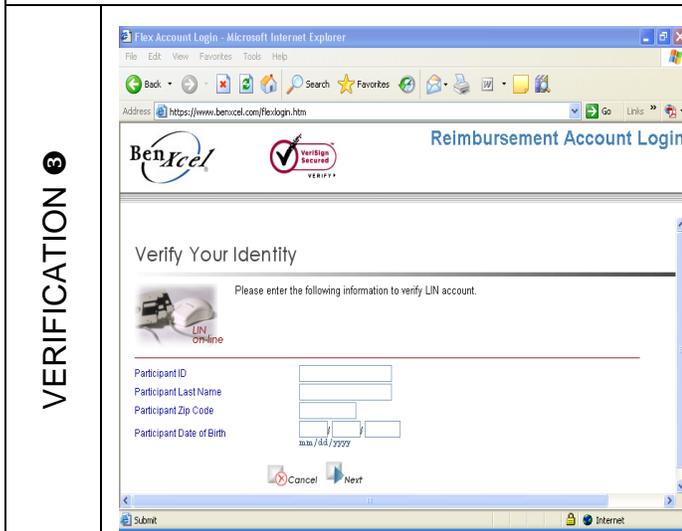
- Logon <https://www.benxcel.com/cooca.htm>
- If prompted, click through the two Security alert banners
- Click “Register New User” on Login Screen



2
CREATE AN ACCOUNT

Set-up User ID & Password

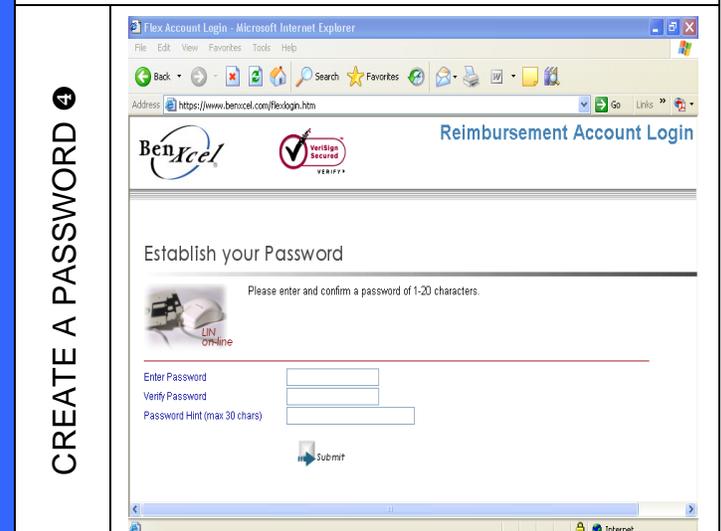
- Enter a unique User ID of 1-20 characters
- Enter a valid email address to be associated with the chosen ID
- Chose the option that applies to you: a.) “I am the subscriber,” or b.) “I am a dependent to the subscriber”
- Click “Next”



3
VERIFICATION

Set-up Account Verification

- Type your “Participant ID” which is SSN without spaces or hyphens – Leave radio dial button as Participant 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”



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.



Important Reminders for the 2015 Open Enrollment

CalPERS Medical Plan Availability

As an active employee you may enroll in a medical plan using either your residential or work zip code. You cannot use a P.O. Box to establish eligibility, but may use it for mailing purposes.

If you use your residential zip code, all enrolled dependents must reside in the health plan's service area. When you use your work zip code, all enrolled dependents must receive all covered services (except emergency and urgent care) within the health plan's service area, even if they do not reside in that service area.

To determine if the health plan you are considering provides service where you reside or work, contact the plan before you enroll. You may also use CalPERS' online service, the *Health Plan Search by ZIP Code*, available at www.calpers.ca.gov and on my|CalPERS at my.calpers.ca.gov.

Adding New Dependents to Your Medical, Dental and/or Vision Plan or Waiving Your Medical Coverage

If adding any new dependents to your health plans, you will need to provide a marriage certificate for a spouse, declaration of domestic partnership for a registered domestic partner, birth certificates for eligible children.

If covering non-dependent children, you will need to submit the ***Affidavit of Parent-Child Relationship, CalPERS form HBD-40***, along with other required documentation, proving the relationship.

If you are waiving medical coverage, you will need to provide proof of other group coverage to be eligible for the waive health allotment per your unit's **MOU** or **Compensation and Benefits Profile**. **This is required each Open Enrollment.**

CalPERS Video Presenting the 2015 CalPERS Health Plans

CalPERS is continuing to offer a video that provides information from expert health plan representatives. Also included with this on-demand video are downloadable materials for the 2015 health plans. The video is available online at www.calpers.ca.gov. Select the "Members" tab and then choose "View Videos & Web Event". Select "Videos" and then "Health Benefits" to find *Presenting the 2014 CalPERS Health Plans*.

Choosing Generic Drugs vs. Brand Name Drugs

When you request Brand Name Drugs over Generic Drugs, you will be charged the difference in cost between the Generic and the Brand Name drugs.

For example, if your doctor prescribes a Generic Drug but the member requests the Brand Name and the Brand Name cost is \$200 but the Generic cost is \$75, the member will pay the \$20 co-payment plus the additional amount of \$125 making the total prescription cost to the member of \$145.

If a physician is specifically stating a member needs a Brand Name Drug, the physician must state "dispense as written on the prescription and the member will receive the Brand Name Drug at the \$20 co-payment. The higher cost will only be if the member is requesting the Brand Name drug.

Flexible Spending Accounts

The U.S. Internal Revenue Service issued **Notice 2012-40** on May 30, 2012, with guidance on the \$2,500 limit on pretax employee contributions to health care flexible spending accounts (FSAs) under the Patient Protection and Affordable Care Act (PPACA). Over-the-counter medications or supplies **are not eligible** for reimbursement. Dependent Care account maximum has not changed and is still \$5,000. **REMINDER: FLEXIBLE SPENDING DOES NOT "ROLLOVER" EACH YEAR. You must elect and designate an amount during each open enrollment to have FSA for the following calendar year.**

Eligibility for Benefits

Employee Eligibility

If you are an active, full-time regular employee you are eligible for the City of Ontario sponsored group benefits. Your coverage for health benefits will be effective on the first of the month following date of enrollment. You will have 30 days from the date of hire to enroll. If the date of hire is the first day of the month, an employee is eligible to enroll on that day.

Dependent Eligibility

- Your legal spouse
- Your domestic partner (California definition)
 - Is your sole spousal equivalent (this means that you cannot be married to someone else or have another domestic partner)
 - Is 18 years old or older
 - Is mentally competent to enter into contracts
 - Resides with you and intends to do so indefinitely
 - Is jointly responsible with you for common financial obligations
 - Is unmarried and not related to you by blood to a degree that would bar marriage in the state of residence
 - The domestic partnership is registered with the state and the domestic partner has not terminated another domestic partnership within the last six months
 - Both parties must be of the same sex or if of the opposite sex, one party must be 62 or older
- Your natural children, stepchildren, and/or adopted children of which the employee is the legal guardian. In addition such children must be:
 - Not in the military
 - Not eligible for any other insurance
 - Under the age of 26 to qualify for medical, dental and vision
 - Life insurance under the age of 23
- Your disabled children over the age of 26. Such disabled children must meet the same conditions as listed above for natural children, stepchildren, adopted children, and in addition is physically or mentally handicapped on the date coverage would otherwise end because of age and continue to be handicapped
- A child of a domestic partner who satisfies the same conditions listed above for natural children, stepchildren, adopted children and in addition:
 - Is not a “qualifying child” (as the term is defined in the Internal Revenue Code) of another individual
- Foster children are not eligible for coverage
- Other dependents enrollment depends on financial and legal custody

This is only a summary of the eligible requirements and is not intended to modify or supersede the requirements of the plan documents and the plan documents will govern in the event of any conflict between this summary and the plan documents.

Rules for Benefit Changes During the Plan 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. With regard to qualified status changes, domestic partners and children of domestic partners will be treated similarly to spouses and dependent children, respectively, to the extent permitted by law.

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
- Change in work schedule, including 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 child’s dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- Change in your place of residence or worksite, including a change that affects the accessibility of network providers
- Change in your or your spouse’s or dependent’s health coverage attributable to your spouse’s or dependent’s employment
- Change in individual’s eligibility for Medicare or Medicaid
- A loss of group health coverage sponsored by a governmental or educational institution, including a state children’s health insurance program under the Social Security Act, the Indian health Service or a health program offered by an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan. (You may not change an election to your health Flexible Spending Account as a result of a loss of group health coverage sponsored by a governmental or educational institution.)
- 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” event 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
- An event that is allowed under the **Children’s Health Insurance Program (CHIP) Reauthorization Act**. Under provisions of the Act, employees have 60 days after the following events to request enrollment:
 - Employee or dependent loses eligibility for Medicaid (known as Medi-Cal) or CHIP (known as Healthy Families in California)
 - Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP
- A change in dependent care provider. A cost change is allowable in the Dependent Care Flexible Spending Account only if the cost change is imposed by a dependent care provider who is not related to you, as defined in Internal Revenue Code Section 152(a)(1) through (8).

Two rules apply to making changes to your benefit during the year:

- Any change you make must be consistent with the change in status, AND
- You must notify the Benefits Division and make the change within days after the date the event occurs (unless otherwise noted above).

You are responsible for notifying the Benefits Division of your dependent(s) that become ineligible as a result of divorce or becoming an overage dependent of the plan with 30 days of the event.

CalPERS Basic Health Plans

During Open Enrollment you may add or delete dependents to your benefit plans. If you add a spouse or child, you must provide the Benefits Division a copy of your marriage certificate, birth certificate or adoption documentation. **If you are waiving medical coverage, you must provide documentation of other group coverage in order to continue receiving your “waive” health allotment.** Documentation of other coverage can be a printout from your current health plan provider’s website showing the group coverage name, or a statement of coverage on the other organization’s company letterhead.

Deciding on a health plan for you and your family can seem challenging and difficult. There are significant differences between HMOs and PPOs, and knowing those differences can make your decision a little easier. For a full listing of health plan options, refer to the ***Health Benefit Summary*** provided by CalPERS.

Health Maintenance Organization (HMO)

HMOs offer members a range of health benefits, including preventive care. The HMO will give you a list of doctors from which you select a primary care provider (PCP). Your PCP coordinates your care, including referrals to specialists. Other than applicable co-payments, you pay no additional costs when you receive pre-authorized services from the HMO’s contracted providers.

If you obtain care outside the HMO’s provider network without a referral from the health plan, you will be responsible for the total cost of services, except for emergency and urgent care.

Preferred Provider Organization (PPO)

Unlike an HMO, where a primary care provider directs all your care, a PPO allows you to select a primary care provider and specialist without referral. A PPO is similar to a traditional “fee-for-service” health plan, but you must use doctors in the PPO network or pay higher co-insurance (percentage of charges). In a PPO health plan, you must meet an annual deductible before some benefits apply. You are responsible for a specific co-insurance amount, and the health plan pays the balance up to the allowable amount.

CalPERS has launched **CalPERS|Compare**, a one-stop-shop for your health information needs.

CalPERS|Compare is available to you now and lets you shop for medical services and prescriptions and compare your options. You can use it to track your past expenses and how much you should expect to pay. If you are enrolled in a CalPERS Anthem Blue Cross PERS Select, PERS Choice, or you can activate your CalPERS|Compare Account at <https://www.calperscompare.com>

When you use a non-participating provider you are responsible for any charges above the amount allowed.

Contacting Your Health Plan

To obtain up-to-date contact information for the health plans, please refer to the CalPERS ***Health Benefit Summary*** or go to CalPERS On-Line at www.calpers.ca.gov. Contact your health plan with questions about: identification cards, verification of provider participation, service area boundaries (covered ZIP Codes) or Individual Conversion Policies. Your plan benefits, deductibles, limitations, and exclusions are outlined in your health plan’s *Evidence of Coverage* booklet. You can obtain the *Evidence of Coverage* by contacting your health plan directly or visiting the CalPERS website.

2015 DH/MGT Employee Rates/Cost

Rates based on CalPERS Basic Premium Rates - Los Angeles, San Bernardino, Ventura Counties

2015 MEDICAL	Tier Level	Total Premium	City Contribution	Employee Cost		
	Waiving Medical					
	On 08/31/04 or Prior	\$ -	\$ 485.00	\$ (485.00)		
	On 09/01/04 or After	\$ -	\$ 420.00	\$ (420.00)		
	Anthem HMO Select				2014 Cost	Difference
	Employee	\$ 493.40	\$ 720.00	\$ (226.60)	\$ (199.14)	\$ (27.46)
	Employee + One	\$ 986.80	\$ 990.00	\$ (3.20)	\$ 61.72	\$ (64.92)
	Family	\$ 1,282.84	\$ 1,230.00	\$ 52.84	\$ 137.24	\$ (84.40)
	Anthem HMO Traditional					
	Employee	\$ 631.62	\$ 720.00	\$ (88.38)	\$ (125.24)	\$ 36.86
	Employee + One	\$ 1,263.24	\$ 990.00	\$ 273.24	\$ 209.52	\$ 63.72
	Family	\$ 1,642.21	\$ 1,230.00	\$ 412.21	\$ 329.38	\$ 82.83
	Health Net Salud y Mas					
	Employee	\$ 430.71	\$ 720.00	\$ (289.29)	\$ (249.56)	\$ (39.73)
	Employee + One	\$ 861.42	\$ 990.00	\$ (128.58)	\$ (39.12)	\$ (89.46)
	Family	\$ 1,119.85	\$ 1,230.00	\$ (110.15)	\$ 6.14	\$ (116.29)
	Health Net SmartCare					
	Employee	\$ 568.47	\$ 720.00	\$ (151.53)	\$ (132.29)	\$ (19.24)
	Employee + One	\$ 1,136.94	\$ 990.00	\$ 146.94	\$ 195.42	\$ (48.48)
	Family	\$ 1,478.02	\$ 1,230.00	\$ 248.02	\$ 311.05	\$ (63.03)
	United Healthcare					
	Employee	\$ 458.74	\$ 720.00	\$ (261.26)	\$ (187.24)	\$ (74.02)
	Employee + One	\$ 917.48	\$ 990.00	\$ (72.52)	\$ 85.52	\$ (158.04)
	Family	\$ 1,192.72	\$ 1,230.00	\$ (37.28)	\$ 168.18	\$ (205.46)
	Blue Shield Access + HMO					
	Employee	\$ 517.87	\$ 720.00	\$ (202.13)	\$ (205.09)	\$ 2.96
	Employee + One	\$ 1,035.74	\$ 990.00	\$ 45.74	\$ 49.82	\$ (4.08)
	Family	\$ 1,346.46	\$ 1,230.00	\$ 116.46	\$ 121.77	\$ (5.31)
	Blue Shield NetValue					
	Employee	\$ 485.41	\$ 720.00	\$ (234.59)	\$ (279.50)	\$ 44.91
	Employee + One	\$ 970.82	\$ 990.00	\$ (19.18)	\$ (99.00)	\$ 79.82
	Family	\$ 1,262.07	\$ 1,230.00	\$ 32.07	\$ (71.70)	\$ 103.77
	Kaiser HMO					
	Employee	\$ 521.18	\$ 720.00	\$ (198.82)	\$ (133.21)	\$ (65.61)
	Employee + One	\$ 1,042.36	\$ 990.00	\$ 52.36	\$ 193.58	\$ (141.22)
	Family	\$ 1,355.07	\$ 1,230.00	\$ 125.07	\$ 308.65	\$ (183.58)
	PERS Choice					
	Employee	\$ 585.18	\$ 720.00	\$ (134.82)	\$ (75.81)	\$ (59.01)
	Employee + One	\$ 1,170.36	\$ 990.00	\$ 180.36	\$ 308.38	\$ (128.02)
	Family	\$ 1,521.47	\$ 1,230.00	\$ 291.47	\$ 457.89	\$ (166.42)
	PERS Select					
	Employee	\$ 576.49	\$ 720.00	\$ (143.51)	\$ (101.17)	\$ (42.34)
	Employee + One	\$ 1,152.98	\$ 990.00	\$ 162.98	\$ 257.66	\$ (94.68)
	Family	\$ 1,498.87	\$ 1,230.00	\$ 268.87	\$ 391.96	\$ (123.09)
	PERSCare					
	Employee	\$ 647.11	\$ 720.00	\$ (72.89)	\$ (50.41)	\$ (22.48)
	Employee + One	\$ 1,294.22	\$ 990.00	\$ 304.22	\$ 359.18	\$ (54.96)
	Family	\$ 1,682.49	\$ 1,230.00	\$ 452.49	\$ 523.93	\$ (71.44)

CalPERS 2015 Health Premiums - Regional Contracting Agencies Only - HMOs' Only June PHBC Proposed Premiums

Basic	2014			2015			Percent Chg (+/-)
	Single	2-Party	Family	Single	2-Party	Family	
Basic Premium Rates - Bay Area							
Alameda, Amador, Contra Costa, Marin, Napa, Nevada, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Sutter, and Yuba							
Anthem HMO Select	\$657.33	\$1,314.66	\$1,709.06	\$662.41	\$1,324.82	\$1,722.27	0.77%
Anthem HMO Traditional	728.41	1,456.82	1,893.87	827.57	1,655.14	2,151.68	13.61%
Blue Shield Access+	836.59	1,673.18	2,175.13	928.87	1,857.74	2,415.06	11.03%
Blue Shield NetValue	704.01	1,408.02	1,830.43	870.60	1,741.20	2,263.56	23.66%
Kaiser CA	742.72	1,485.44	1,931.07	714.45	1,428.90	1,857.57	-3.81%
UnitedHealthcare	764.24	1,528.48	1,987.02	850.67	1,701.34	2,211.74	11.31%
Basic Premium Rates - Sacramento Area							
El Dorado, Placer, Sacramento, and Yolo							
Anthem HMO Select	\$750.27	\$1,500.54	\$1,950.70	\$811.14	\$1,622.28	\$2,108.96	8.11%
Anthem HMO Traditional	840.43	1,680.86	2,185.12	940.16	1,880.32	2,444.42	11.87%
Blue Shield Access+	734.87	1,469.74	1,910.66	809.22	1,618.44	2,103.97	10.12%
Blue Shield NetValue	618.39	1,236.78	1,607.81	758.45	1,516.90	1,971.97	22.65%
Kaiser CA	681.59	1,363.18	1,772.13	660.96	1,321.92	1,718.50	-3.03%
UnitedHealthcare	643.34	1,286.68	1,672.68	623.45	1,246.90	1,620.97	-3.09%
Basic Premium Rates - Los Angeles Area							
Los Angeles, San Bernardino, and Ventura							
Anthem HMO Select	\$475.86	\$951.72	\$1,237.24	\$493.40	\$986.80	\$1,282.84	3.69%
Anthem HMO Traditional	549.76	1,099.52	1,429.38	631.62	1,263.24	1,642.21	14.89%
Blue Shield Access+	469.91	939.82	1,221.77	517.87	1,035.74	1,346.46	10.21%
Blue Shield NetValue	395.50	791.00	1,028.30	485.41	970.82	1,262.07	22.73%
Health Net Salud y Más	425.44	850.88	1,106.14	430.71	861.42	1,119.85	1.24%
Health Net SmartCare	542.71	1,085.42	1,411.05	568.47	1,136.94	1,478.02	4.75%
Kaiser CA	541.79	1,083.58	1,408.65	521.18	1,042.36	1,355.07	-3.80%
United Healthcare	487.76	975.52	1,268.18	458.74	917.48	1,192.72	-5.95%
Basic Premium Rates - Other Southern California							
Fresno, Imperial, Inyo, Kern, Kings, Madera, Riverside, Orange, San Diego, San Luis Obispo, Santa Barbara, and Tulare							
Anthem HMO Select	\$536.99	\$1,073.98	\$1,396.17	\$653.97	\$1,307.94	\$1,700.32	21.78%
Anthem HMO Traditional	592.20	1,184.40	1,539.72	743.12	1,486.24	1,932.11	25.48%
Blue Shield Access+	543.21	1,086.42	1,412.35	598.66	1,197.32	1,556.52	10.21%
Blue Shield NetValue	457.17	914.34	1,188.64	561.09	1,122.18	1,458.83	22.73%
Health Net Salud y Más	489.82	979.64	1,273.53	520.59	1,041.18	1,353.53	6.28%
Health Net SmartCare	568.51	1,137.02	1,478.13	579.88	1,159.76	1,507.69	2.00%
Kaiser CA	602.79	1,205.58	1,567.25	579.80	1,159.60	1,507.48	-3.81%
Sharp	538.59	1,077.18	1,400.33	564.57	1,129.14	1,467.88	4.82%
UnitedHealthcare	521.01	1,042.02	1,354.63	449.10	898.20	1,167.66	-13.80%

CalPERS 2015 Health Premiums - Regional Contracting Agencies Only - HMOs' Only June PHBC Proposed Premiums

Basic	2014			2015			Percent Chg (+/-)
	<i>Single</i>	<i>2-Party</i>	<i>Family</i>	<i>Single</i>	<i>2-Party</i>	<i>Family</i>	
Basic Premium Rates - Other Northern California							
Alpine, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Plumas, San Benito, Shasta, Sierra, Siskiyou, Stanislaus, Tehama, Trinity, and Tuolumne							
Anthem HMO Select	\$706.20	\$1,412.40	\$1,836.12	\$728.65	\$1,457.30	\$1,894.49	3.18%
Anthem HMO Traditional	767.36	1,534.72	1,995.14	838.48	1,676.96	2,180.05	9.27%
Blue Shield Access+	729.76	1,459.52	1,897.38	804.34	1,608.68	2,091.28	10.22%
Blue Shield NetValue	614.13	1,228.26	1,596.74	753.82	1,507.64	1,959.93	22.75%
Kaiser CA	745.30	1,490.60	1,937.78	716.98	1,433.96	1,864.15	-3.80%
UnitedHealthcare	659.06	1,318.12	1,713.56	677.35	1,354.70	1,761.11	2.78%
Basic Premium Rates - Out of State							
Kaiser/Out of State	\$917.20	\$1,834.40	\$2,384.72	\$922.78	\$1,845.56	\$2,399.23	0.61%

Medicare	2014			2015			Percent Chg (+/-)
	<i>Single</i>	<i>2-Party</i>	<i>Family</i>	<i>Single</i>	<i>2-Party</i>	<i>Family</i>	
Medicare Premium Rates - All Regions							
Anthem Blue Cross	\$341.12	\$682.24	\$1,023.36	\$445.38	\$890.76	\$1,336.14	30.56%
Blue Shield	298.21	596.42	894.63	352.63	705.26	1,057.89	18.25%
Health Net	261.24	522.48	783.72	276.85	553.70	830.55	5.98%
Kaiser CA	294.97	589.94	884.91	295.51	591.02	886.53	0.18%
Kaiser Out of State	388.65	777.30	1,165.95	390.47	780.94	1,171.41	0.47%
Sharp	306.51	613.02	919.53	327.66	655.32	982.98	6.90%
UnitedHealthcare	193.33	386.66	579.99	267.41	534.82	802.23	38.32%

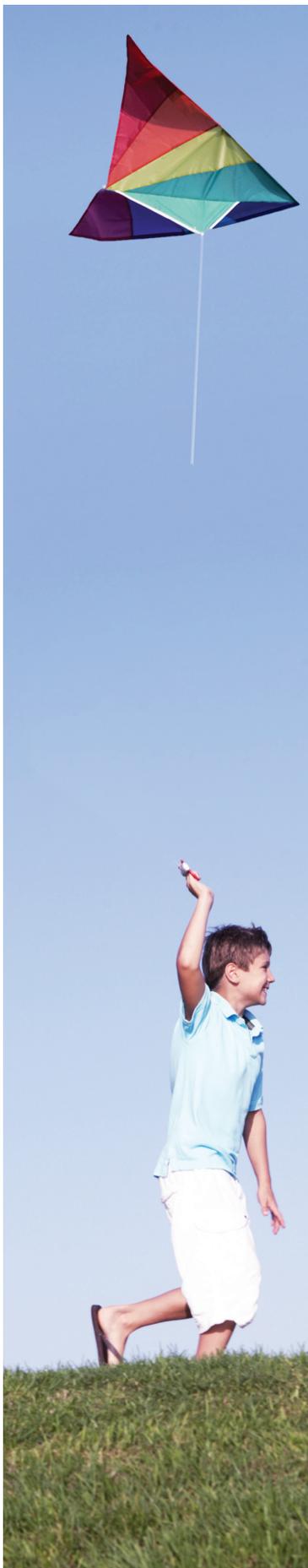
**CalPERS 2015 Health Premiums - Regional
Contracting Agencies Only - PPOs Only
June PHBC Proposed Premiums**

Basic	2014			2015			Percent Change (+/-)
	<i>Single</i>	<i>2-Party</i>	<i>Family</i>	<i>Single</i>	<i>2-Party</i>	<i>Family</i>	
Basic Premium Rates - Bay Area							
<i>Alameda, Amador, Contra Costa, Marin, Napa, Nevada, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Sutter, and Yuba</i>							
PERS Choice	\$690.77	\$1,381.54	\$1,796.00	\$700.84	\$1,401.68	\$1,822.18	1.46%
PERS Select	661.52	1,323.04	1,719.95	690.43	1,380.86	1,795.12	4.37%
PERSCare	720.04	1,440.08	1,872.10	775.08	1,550.16	2,015.21	7.64%
Basic Premium Rates - Sacramento Area							
<i>El Dorado, Placer, Sacramento, and Yolo</i>							
PERS Choice	\$665.99	\$1,331.98	\$1,731.57	\$679.26	\$1,358.52	\$1,766.08	1.99%
PERS Select	637.85	1,275.70	1,658.41	669.16	1,338.32	1,739.82	4.91%
PERSCare	694.26	1,388.52	1,805.08	751.21	1,502.42	1,953.15	8.20%
Basic Premium Rates - Los Angeles Area							
<i>Los Angeles, San Bernardino, and Ventura</i>							
PERS Choice	\$599.19	\$1,198.38	\$1,557.89	\$585.18	\$1,170.36	\$1,521.47	-2.34%
PERS Select	573.83	1,147.66	1,491.96	576.49	1,152.98	1,498.87	0.46%
PERSCare	624.59	1,249.18	1,623.93	647.11	1,294.22	1,682.49	3.61%
Basic Premium Rates - Other Southern California							
<i>Fresno, Imperial, Inyo, Kern, Kings, Madera, Riverside, Orange, San Diego, San Luis Obispo, Santa Barbara, and Tulare</i>							
PERS Choice	\$612.25	\$1,224.50	\$1,591.85	\$594.40	\$1,188.80	\$1,545.44	-2.92%
PERS Select	586.32	1,172.64	1,524.43	585.58	1,171.16	1,522.51	-0.13%
PERSCare	638.22	1,276.44	1,659.37	657.32	1,314.64	1,709.03	2.99%
Basic Premium Rates - Other Northern California							
<i>Alpine, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Plumas, San Benito, Shasta, Sierra, Siskiyou, Stanislaus, Tehama, Trinity, and Tuolumne</i>							
Anthem EPO	\$767.36	\$1,534.72	\$1,995.14	\$656.08	\$1,312.16	\$1,705.81	-14.50%
PERS Choice	641.08	1,282.16	1,666.81	656.08	1,312.16	1,705.81	2.34%
PERS Select	613.99	1,227.98	1,596.37	646.35	1,292.70	1,680.51	5.27%
PERSCare	668.27	1,336.54	1,737.50	725.54	1,451.08	1,886.40	8.57%
Basic Premium Rates - Out of State							
PERS Choice	\$706.40	\$1,412.80	\$1,836.64	\$653.58	\$1,307.16	\$1,699.31	-7.48%
PERSCare	736.32	1,472.64	1,914.43	722.74	1,445.48	1,879.12	-1.84%
Medicare							
Medicare	2014			2015			Percent Change (+/-)
	<i>Single</i>	<i>2-Party</i>	<i>Family</i>	<i>Single</i>	<i>2-Party</i>	<i>Family</i>	
Medicare Premium Rates - All Regions							
PERS Choice	\$307.23	\$614.46	\$921.69	\$339.47	\$678.94	\$1,018.41	10.49%
PERS Select	307.23	614.46	921.69	339.47	678.94	1,018.41	10.49%
PERSCare	327.36	654.72	982.08	368.76	737.52	1,106.28	12.65%

2015 DH/MGT Dental and Vision Monthly Rates/Cost

2015 DENTAL	Tier Level	Total Premium	City Contribution	Employee Cost
	Delta PMI/DHMO			
	Employee	\$ 22.98	\$ 22.98	\$ -
	Employee + One	\$ 42.88	\$ 42.88	\$ -
	Family	\$ 64.32	\$ 64.32	\$ -
	Delta DPO			
	Employee	\$ 46.30	\$ 46.30	\$ -
	Employee + One	\$ 87.70	\$ 87.70	\$ -
	Family	\$ 132.90	\$ 132.90	\$ -
	Delta DPO Buy Up			
	Employee	\$ 51.30	\$ 46.30	\$ 5.00
	Employee + One	\$ 91.10	\$ 87.70	\$ 3.40
Employee + Family	\$ 138.00	\$ 132.90	\$ 5.10	

2015 VISION	VSP			
	Employee	\$ 6.01	\$ 6.01	\$ -
	Employee + One	\$ 10.46	\$ 10.46	\$ -
	Employee + Family	\$ 18.78	\$ 18.78	\$ -
	VSP Buy Up			
	Employee	\$ 10.62	\$ 6.01	\$ 4.61
Employee + One	\$ 18.48	\$ 10.46	\$ 8.02	
Employee + Family	\$ 33.14	\$ 18.78	\$ 14.36	



9 WAYS TO ELEVATE YOUR SMILE



1. VISIT YOUR DELTACARE USA DENTIST. You must visit your selected DeltaCare USA general dentist to receive benefits under your plan. Find or change your dentist at deltadentalins.com¹ or by calling Customer Service. Don't want to choose a dentist on your own? We can designate one for you.

- › No ID card is necessary to receive treatment – just provide your dentist with your name, date of birth and social security or enrollee ID number.
- › There are no claims forms to complete – just pay your copayment (if any) at the time of treatment.
- › If you require treatment from a specialist, your DeltaCare USA general dentist will coordinate a referral for you.²



2. SEEK PREVENTIVE CARE. Regular cleanings are a great way to keep your smile bright and may catch problems before more costly and extensive services are necessary. Your plan is designed with low or no costs for routine cleanings and exams.

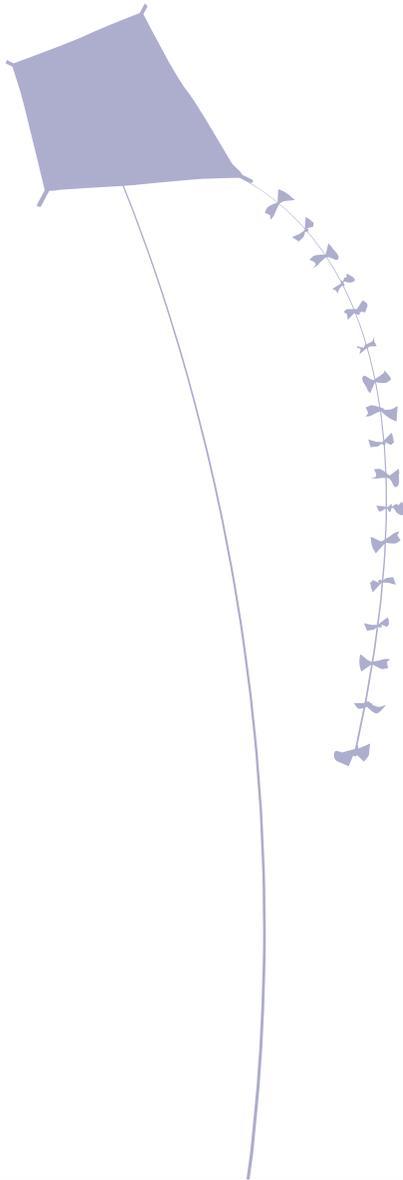


3. ACCESS ONLINE SERVICES. Create a free Online Services account to access plan information online anytime including benefits, eligibility, ID card and more.

GET THE MOST FROM YOUR DELTACARE[®] USA PLAN

¹ Changes received by the 21st of the month will be effective the first day of the following month. Verify that the dentist is your selected DeltaCare USA primary care dentist before each appointment.

² In some states, Delta Dental must pre-authorize any non-emergency dental services provided by a specialist. Refer to your plan booklet for details about your plan.



4. STUDY YOUR PLAN. Did you know that DeltaCare USA has no exclusions for pre-existing conditions, including missing teeth?³ Read your plan booklet for a complete list of covered procedures, copayments, plan limitations and exclusions.



5. GET MOBILE. Visit deltadentalins.com on your smartphone to access mobile-optimized Online Services – including a helpful dentist locator tool – on the go. Or, download the Delta Dental app through the App Store or Google Play to access your plan and try out our toothbrush timer.



6. COORDINATE BENEFITS. Are you covered under another dental plan as well? We may coordinate payment if you receive authorized treatment from a specialist. Ask your dental specialist to include information about both plans with your claim, and we'll handle the rest.³



7. COMPLETE IN-PROGRESS ORTHODONTIC CARE. If you began orthodontic treatment under a previous employer-sponsored plan, our treatment-in-progress provision may allow you to continue active treatment with your current orthodontist. Your prior plan's copayments and fees will apply.⁴



8. TALK TO YOUR DENTIST. From pregnancy to diabetes, medical conditions can affect your oral health. Start each dental checkup with a quick chat about your overall health.



9. STAY INFORMED. Get tools and tips to keep your smile bright at our SmileWay® Wellness site (mysmileway.com). And, subscribe to *Grin!*, our free dental health e-newsletter.

³ Group- and state-specific exceptions may apply. Please review your plan booklet for details about your plan's coordination of benefits, including rules for determining primary and secondary coverage.

⁴ This provision may not apply to all plans. Please refer to your plan booklet for specific coverage details.

LEGAL NOTICES: Access federal and state legal notices related to your plan: deltadentalins.com/about/legal/index-enrollee.html

DeltaCare USA is underwritten in these states by these entities: AL – Alpha Dental of Alabama, Inc.; AZ – Alpha Dental of Arizona, Inc.; CA – Delta Dental of California; AR, CO, IA, ME, MI, NC, NE, NH, OK, OR, RI, SC, SD, VT, WA, WI, WY – Dentegra Insurance Company; AK, CT, DE, FL, GA, KS, LA, MS, MT, TN, WV and the District of Columbia – Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX – Alpha Dental Programs, Inc.; NV – Alpha Dental of Nevada, Inc.; UT – Alpha Dental of Utah, Inc.; NM – Alpha Dental of New Mexico, Inc.; NY – Delta Dental of New York, Inc.; PA – Delta Dental of Pennsylvania; VA – Delta Dental of Virginia. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

CONTACT US

Online assistance:

For quick and easy online assistance, go to deltadentalins.com › Contact Us › then select the administering company and choose the applicable customer service form.

Telephone assistance:

DeltaCare USA: **800-422-4234 (toll free)**

› Use our interactive voice response system: 7 days a week, 4:30 a.m. – 9:30 p.m. Pacific time

› Speak to a Customer Service representative: Monday-Friday, 5 a.m. – 6 p.m. Pacific time



Delta Dental PPOSM – Easy, Friendly, Accessible

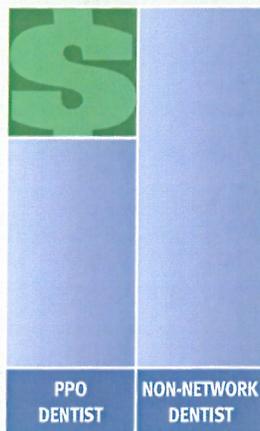


We'll do whatever it takes and then some.

Greatest potential savings when you visit a Delta Dental PPO dentist

OUT-OF-POCKET COSTS

SAVE MORE SAVE LESS



AMOUNT YOU SAVE
AMOUNT YOU PAY

Illustration showing sample enrollee share of cost for information purposes only. Actual dentist fees and contract allowances will vary by region, procedure and by group contract.

We're pleased to be your partner in maintaining great oral health. The Delta Dental PPO* plan makes it easy for you to find a dentist, and easy to control your costs when you visit a network dentist. Here are some of the great things you'll need to know about enrolling with Delta Dental:

- **Save money with a Delta Dental PPO dentist.** Our PPO network dentists accept reduced fees for covered services they provide you, so you'll usually pay the least when you visit a PPO network dentist. This also ensures Delta Dental PPO dentists won't balance bill you the difference between the contracted amount and their usual fee.
- **Visit the dentist of your choice.** Want to visit a non-Delta Dental dentist? No problem. You can visit any licensed dentist, but your costs are usually lowest when you see a PPO dentist.
- **Many network dentists to choose from.** Since Delta Dental offers access to one of the largest dentist networks in the U.S., chances are there's a wide choice of network dentists near your home or office. Many dentists nationwide are contracted Delta

Dental dentists, giving more enrollees convenient access to more dentists. Visit us at deltadentalins.com to search our dentist directory by location or specialty.

- **Easy to use your benefits.** When you visit a Delta Dental dentist, pay only your portion for services. Delta Dental dentists will file claim forms for you and receive payment directly from us. Many non-Delta Dental dentists ask that you pay the entire cost up front and wait for reimbursement.
- **Delta Dental's Online Services make getting information quick and easy.** Access your benefits and eligibility, print ID cards and get information about your claims. And check out Delta Dental's oral health resources for tips and information that can help keep your smile healthy.

* In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.



WE KEEP YOU SMILING®

Plan Benefit Highlights for: City of Ontario (Base Plan)

Group No: 16105

Effective Date: 01/01/2014

DELTA DENTAL PPOSM

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to age 26.			
Deductibles	In-network: \$10 per person / \$30 per family each calendar year Out-of-network: \$25 per person / \$75 per family each calendar year			
Deductibles waived for D & P?	Yes			
Maximums	\$1,000 per person per calendar year			
DP counts toward maximum?	Yes			
Waiting Period(s)	Basic Benefits None	Crowns & Cast None	Prosthodontics 12 Months	Orthodontics 12 Months

Benefits and Covered Services*	Delta Dental PPO dentists** In-PPO Network	Non-PPO dentists** Out-of-PPO Network
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays	100 %	100 %
Basic Services Fillings, simple tooth extractions, sealants	90 %	80 %
Endodontics (root canals) Covered Under Basic Services	90 %	80 %
Periodontics (gum treatment) Covered Under Basic Services	90 %	80 %
Oral Surgery Covered Under Basic Services	90 %	80 %
Major Services Crowns, inlays, onlays and cast restorations, bridges and dentures, implants	60 %	50 %
Orthodontic Benefits dependent children	50 %	50 %
Orthodontic Maximums	\$ 1,000 Lifetime	\$ 1,000 Lifetime

BENEFIT HIGHLIGHTS

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California
100 First St.
San Francisco, CA 94105

Customer Service
800-765-6003

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Plan Benefit Highlights for: City of Ontario (Buy-Up plan)

Group No: 16105

Effective Date: 01/01/2014

DELTA DENTAL PPOSM

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to age 26.			
Deductibles	In-network: \$10 per person / \$30 per family each calendar year Out-of-network: \$25 per person / \$75 per family each calendar year			
Deductibles waived for D & P?	Yes			
Maximums	\$1,000 per person per calendar year			
DP counts toward maximum?	No			
Waiting Period(s)	Basic Benefits None	Crowns & Cast None	Prostodontics 12 Months	Orthodontics 12 Months

Benefits and Covered Services*	Delta Dental PPO dentists** In-PPO Network	Non-PPO dentists** Out-of-PPO Network
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Basic Services Fillings, simple tooth extractions, sealants	90 %	80 %
Endodontics (root canals) Covered Under Basic Services	90 %	80 %
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Oral Surgery Covered Under Basic Services	90 %	80 %
Major Services Crowns, inlays, onlays and cast restorations, bridges and dentures, implants	60 %	50 %
Orthodontic Benefits dependent children	50 %	50 %
Orthodontic Maximums	\$ 1,000 Lifetime	\$ 1,000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California 100 First St. San Francisco, CA 94105	Customer Service 800-765-6003	Claims Address P.O. Box 997330 Sacramento, CA 95899-7330
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deltadentalins.com

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Your Vision Benefit Summary

Keep your eyes healthy with CITY OF ONTARIO and VSP® Vision Care.

Using your VSP benefit is easy.

- **Find an eyecare provider who's right for you.**
You can choose to see any eyecare provider—your local VSP doctor, a retail chain affiliate, or any other provider. To find a VSP doctor or retail chain affiliate, visit vsp.com or call **800.877.7195**.
- **Review your benefit information.** Visit vsp.com to review your plan coverage before your appointment.
- **At your appointment, tell them you have VSP.** There's no ID card necessary.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP doctor or retail chain affiliate.

Personalized Care

You'll get quality care that focuses on your eyes and overall wellness with VSP. Plus, your satisfaction is guaranteed when you see a VSP doctor.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options for you and your family. You'll have access to great brands, like bebe®, Calvin Klein, Disney, FENDI, Nike, and Tommy Bahama®.

Plan Information

VSP Doctor Network: VSP Choice

Benefit	Description	Copay
Your Coverage with VSP Doctors and Affiliate Providers*		
WellVision Exam	<ul style="list-style-type: none"> • Focuses on your eyes and overall wellness • Every 12 months 	\$20 for exam and glasses
Prescription Glasses		
Frame	<ul style="list-style-type: none"> • \$120 allowance for a wide selection of frames • 20% off amount over your allowance • \$70 allowance at Coscto • Every 24 months 	Combined with exam
Lenses	<ul style="list-style-type: none"> • Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 24 months 	Combined with exam
Lens Options	<ul style="list-style-type: none"> • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 20-25% off other lens options • Every 24 months 	\$55 \$95 - \$105 \$150 - \$175
Contacts (instead of glasses)	<ul style="list-style-type: none"> • \$120 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 24 months 	Up to \$60
Additional Coverage	• Diabetic Eyecare Plus Program	
Extra Savings and Discounts	Glasses and Sunglasses	
	<ul style="list-style-type: none"> • 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam. 	
	Retinal Screening	
	<ul style="list-style-type: none"> • Guaranteed pricing on retinal screening as an enhancement to your WellVision Exam. 	
	Laser Vision Correction	
	<ul style="list-style-type: none"> • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities 	
Your Coverage with Other Providers		
Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.		
Exam.....	up to \$45	Lined Trifocal Lenses..... up to \$65
Frame.....	up to \$70	Progressive Lenses..... up to \$50
Single Vision Lenses.....	up to \$30	Contacts..... up to \$105
Lined Bifocal Lenses.....	up to \$50	
<small>*Coverage with a retail chain affiliate may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.</small>		

Visit vsp.com or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

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- **Review your benefit information.** Visit vsp.com to review your plan coverage before your appointment.
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From classic styles to the latest designer frames, you'll find hundreds of options for you and your family. You'll have access to great brands, like bebe®, Calvin Klein, Disney, FENDI, Nike, and Tommy Bahama®.

Plan Information

VSP Doctor Network: VSP Choice

Benefit	Description	Copay
Your Coverage with VSP Doctors and Affiliate Providers*		
WellVision Exam	<ul style="list-style-type: none"> • Focuses on your eyes and overall wellness • Every 12 months 	\$10 for exam and glasses
Prescription Glasses		
Frame	<ul style="list-style-type: none"> • \$150 allowance for a wide selection of frames • 20% off amount over your allowance • \$80 allowance at Costco • Every 12 months 	Combined with exam
Lenses	<ul style="list-style-type: none"> • Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months 	Combined with exam
Lens Options	<ul style="list-style-type: none"> • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 20-25% off other lens options • Every 12 months 	\$55 \$95 - \$105 \$150 - \$175
Contacts (instead of glasses)	<ul style="list-style-type: none"> • \$120 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months 	Up to \$60
Additional Coverage	• Diabetic Eyecare Plus Program	
Extra Savings and Discounts	Glasses and Sunglasses	
	<ul style="list-style-type: none"> • 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam. 	
	Retinal Screening	
	<ul style="list-style-type: none"> • Guaranteed pricing on retinal screening as an enhancement to your WellVision Exam. 	
	Laser Vision Correction	
	<ul style="list-style-type: none"> • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities 	
Your Coverage with Other Providers		
Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.		
Exam.....	up to \$45	Lined Trifocal Lenses..... up to \$65
Frame.....	up to \$70	Progressive Lenses..... up to \$50
Single Vision Lenses.....	up to \$30	Contacts..... up to \$105
Lined Bifocal Lenses.....	up to \$50	
<p>*Coverage with a retail chain affiliate may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.</p>		

Visit vsp.com or call 800.877.7195 for more details on your vision coverage and exclusive savings and promotions for VSP members.

2015 Flexible Spending Account Information

The City of Ontario offers its employees a Flexible Spending Account (FSA) program. This program allows you to pay for out of pocket health/medical expenses and dependent care (day care) with pre-tax dollars. Participants must designate the FSA election amount for the 2015 calendar year during this Open Enrollment period. This amount is deducted from your paycheck in equal installments on a pre-tax basis and credited to your FSA account(s). Our third party administrator, Benefit Coordinators Corporation (BCC), will reimburse you through direct deposit or by mailing you a check. You do not pay federal, state income tax or Social Security on FSA expenses.

Federal law prohibits any change in your FSA during the calendar year unless you or your dependent(s) have a qualifying "life event". A qualifying "life event" is marriage, divorce or legal separation, birth or adoption or a dependent, death of a dependent, or a change in your or your spouse's employment status. In addition, the FSA change must be due to and consistent with the "life event" which permits the change. For example, an increase in FSA contribution would be consistent with birth or adoption of a child; a decrease in contribution may not.

CAUTION: When estimating your annual expenses, consider only those that you are reasonably certain to incur. Any amount left in your FSA at the end of the year is forfeited. The account is left open for claims until March 31st of the following year, but expenses must have been incurred in the same calendar year in which the payroll deduction occurred.

HEALTH CARE REIMBURSEMENT ACCOUNT

Eligible expenses include health-related expenses not covered by your health plan(s) or reimbursed from any other source, for you or any of your dependents (as defined by IRS regulations). As you incur eligible expenses, you are reimbursed up to the amount of your annual election. **Maximum amount allowed for 2015 remains at \$2,500.**

An IRS ruling established that over-the-counter drugs and medicines are no longer allowed to be paid for with pre-tax dollars through FSA.

Health Insurance Premiums are not eligible for FSA Health Care reimbursement. Payroll deductions for the City's group health plans are already made on a pre-tax basis. Therefore, the premiums you pay cannot be reimbursed from your FSA account or deducted on your personal income tax return.

DEPENDENT CARE REIMBURSEMENT ACCOUNT

Eligible expenses include baby-sitter, companion or day-care expenses **necessary so that you can work**; if you are married, the expenses must be **necessary so that both you and your spouse can work**. As you incur eligible expenses, you are reimbursed for the amount of expenses, up to the balance in your FSA account. Employees may select up to a maximum amount of \$5,000 per plan year.

For "child care" the **maximum age for dependent children (as defined by the IRS regulations) is age 13**, unless the dependent is physically or mentally unable to care of himself or herself. The dependent must spend at least eight hours per day in your home. "Overnight Camp" expenses are specifically not eligible.

Dependent Care is not restricted to "child care". Expenses you incur to provide companion or day-care expenses to any individual who qualifies as a dependent for IRS purposes can be reimbursed in the FSA program. Generally, any individual who is related to you, your spouse, is unmarried, is a US citizen or resident alien, and is dependent upon you for more than half of their total support can qualify as a "dependent" for purposes of this program. Thus, expenses you incur to provide "day-care" for a parent may be eligible expenses under the FSA program. Check with your tax advisor for specific advice.

According to the terms of the Family Support Act of 1988, there are two tax benefits available for dependent care expenses: a tax credit on your tax return, or income exclusion under an employer-sponsored spending account (FSA). Any expenses reimbursed through an FSA reduce, dollar-for-dollar, the maximum tax credit. **This law restricts you to using one or other, but not both.** You should consult a tax advisor for an evaluation of your specific circumstances prior to selecting a method for dependent care expense credit.



TOGETHER, CHANGING LIVES

September 2014



Every dollar counts and it all adds up!

By giving to the Inland Empire United Way's Community Impact Fund you can make a real difference in the lives of people right here in the Inland Empire.

\$2 CAN FEED A CHILD

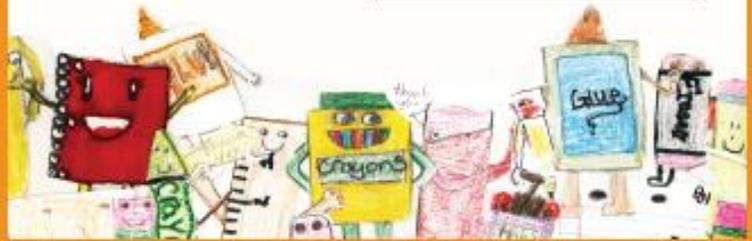
\$5 CAN TURN INTO 10 TIMES THAT AMOUNT IN SCHOOL SUPPLIES

\$10 CAN HELP PROVIDE HOUSING TO A HOMELESS FAMILY OF FOUR

Pledge Today!

for more info
YOUR CONTACT IS:

Sylvia Rodriguez, Human Resources



FIND MORE INFORMATION AT

WWW.IEUW.ORG

SCAN THIS CODE TO VIEW OUR VIDEO AND LEARN MORE!

GIVE. ADVOCATE. VOLUNTEER.
LIVE UNITED



Obtaining Health Care Quality Information

Source	Website	Description
CalHospitalCompare	www.CalHospitalCompare.org	CalHospitalCompare is a standardized, universal performance report card for California hospitals that includes patient experience and clinical quality measures.
U.S. Department of Health and Human Services	www.hospitalcompare.hhs.gov	This site provides publicly-reported hospital quality information, including measures on heart attacks, pneumonia, heart failure, and surgery.
HealthGrades	www.healthgrades.com	HealthGrades uses data from Medicare and states to compare outcomes of care for common procedures.
The Leapfrog Group	www.leapfroggroup.org	This is a coalition of health purchasers who have found that hospitals meeting certain standards have better care results.
California Medical Board	www.medbd.ca.gov	This is the State agency that licenses medical doctors, investigates complaints, disciplines those who violate the law, conducts physician evaluations, and facilitates rehabilitation where appropriate.
Office of the Patient Advocate	www.opa.ca.gov	This website includes a State of California-sponsored "Report Card" that contains additional clinical and member experience data on HMOs and medical groups in California.

To Contact Ontario Plan Providers Directly:

Plan	Website	Member Service
Blue Shield of California	www.blueshieldca.com/calpers	1-800-334-5847
Kaiser Permanente	www.kp.org/calpers	1-800-464-4000
PERS Select, Choice, Care	www.anthem.com/ca/calpers	1-877-737-7776
CVS Caremark	www.caremark.com/calpers	1-877-542-0284
PORAC	www.porac.org	1-800-937-6722
Delta Dental DHMO	www.deltadentalins.com	1-800-422-4234
Delta Dental PPO & Buy-Up	www.deltadentalins.com	1-800-765-6003
VSP Basic & Buy-Up	www.vsp.com	1-800-877-7195
Flexible Spending Accounts	www.benxcel.com/cooca.htm	1-800-685-6100 Option 3
Benefits Coordinators Corp	www.benxcel.com/cooca.htm	1-800-685-6100 Option 3

Women's Health and Cancer Rights Annual Notice

The Women's Health and Cancer Rights Act ("WHCRA") requires City of Ontario to notify participants and beneficiaries of the City of Ontario Group Health Plan (the "Plan"), of their rights to mastectomy benefits under the Plan. Participants and beneficiaries have rights to coverage to be provided in a manner determined in consultation with the attending Physician 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 are subject to the same deductible and co-payments applicable to other medical and surgical benefits provided under this Plan. For further details, please refer to the Plan's Summary Plan Description.

For more information on WHCRA benefits, call (909) 395-2433.

Newborn's and Mothers' Health Protection Act of 1996 (NMHPA)

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of Availability of HIPAA Privacy Notice

The federal Health Insurance Portability and Accountability Act (HIPAA) requires that we periodically remind you of your right to receive a copy of the City of Ontario's HIPAA Privacy Notice. You can request a copy of the Privacy Notice by contacting the Human Resources Department. HIPAA Privacy Notices that pertain to the plans may be obtained by contacting your insurance carrier directly.

For more information on any of these topics, please contact Benefits at (909) 395-2433 or by email at benefits@ci.ontario.ca.us.

Important Notice from City of Ontario about Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Ontario 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 premium.
2. The City of Ontario has determined that the prescription drug coverage offered by the CalPERS medical plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current City of Ontario coverage will be affected. For those individuals who elect Part D coverage, coverage under the City of Ontario will end for the individual and all covered dependents.

If you do decide to join a Medicare drug plan and drop your current City of Ontario coverage, be aware that you and your dependents will 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 City of Ontario 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 credible 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. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Ontario changes. You also may request a copy of this notice at any time.

CONTACT: City of Ontario, Human Resources, Benefits at (909) 395-2433 or email at benefits@ci.ontario.c.a.us.

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore Maryland 21244-1850.

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 1-800-MEDICARE (1-800-772-1213). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For more 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: September 5, 2014
Name of Entity/Sender: City of Ontario
Contact—Position/Office: Human Resources-Benefits
Address: 303 East “B” Street, Ontario, CA 91764
Phone Number: (909) 395-2433

City of Ontario
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how protected health information (or “PHI”) may be used or disclosed by us [or your Group Health Plan] to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your PHI, and describes your rights to access, amend and manage your PHI.

PHI is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices had been drafted to be consistent with what is known as the “HIPAA Privacy Rule,” and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact: Human Resources, 415 East B Street, Ontario, CA 91764 or (909) 395-2433.

EFFECTIVE DATE

This Notice of Privacy Practices becomes effective on September 23, 2013.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your PHI. We are obligated to: provide you with a copy of this Notice of our legal duties and of our privacy practices related to your PHI; abide by the terms of the Notice that is currently in effect; and notify you in the event of a breach of your unsecured PHI. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will make the revised Notice available by mailing to address on file and/or interoffice mail and/or by posting on City’s website.

Permissible Uses and Disclosures of PHI

The following is a description of how we are most likely to use and/or disclose your PHI.

▪ ***Payment and Health Care Operations***

We have the right to use and disclose your PHI for all activities that are included within the definitions of “payment” and “health care operations” as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.

➤ ***Payment***

We will use or disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your PHI when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

➤ ***Health Care Operations***

We will use or disclose your PHI to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your PHI: (i) to provide you with information about a disease management program; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

Other Permissible Uses and Disclosures of PHI

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your PHI.

▪ ***Required by Law***

We may use or disclose your PHI to the extent the law requires the use or disclosure. When used in this Notice, “required by law” is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

▪ ***Public Health Activities***

We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

▪ ***Health Oversight Activities***

We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

▪ ***Abuse or Neglect***

We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence.

▪ ***Legal Proceedings***

We may disclose your PHI: (i) in the course of any judicial or administrative proceeding; (ii) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (iii) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

▪ ***Law Enforcement***

Under certain conditions, we also may disclose your PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (i) it is required by law or some other legal process; (ii) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (iii) it is necessary to provide evidence of a crime that occurred on our premises.

▪ ***Coroners, Medical Examiners, Funeral Directors; Organ Donation Organizations***

We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

▪ ***Research***

We may disclose your PHI to researchers when an institutional review board or privacy board has: (i) reviewed the research proposal and established protocols to ensure the privacy of the information; and (ii) approved the research.

▪ ***To Prevent a Serious Threat to Health or Safety***

Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

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- ***Military Activity and National Security, Protective Services***
Under certain conditions, we may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

- ***Inmates***
If you are an inmate of a correctional institution, we may disclose your PHI to the correctional institution or to a law enforcement official for: (i) the institution to provide health care to you; (ii) your health and safety and the health and safety of others; or (iii) the safety and security of the correctional institution.

- ***Workers' Compensation***
We may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

- ***Emergency Situations***
We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will disclose only the PHI that is directly relevant to the person's involvement in your care.

- ***Fundraising Activities***
We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

- ***Group Health Plan Disclosures***
We may disclose your PHI to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to you. We can disclose your PHI to that entity if that entity has contracted with us to administer your health care program on its behalf.

- ***Underwriting Purposes***
We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing in the underwriting process your PHI that is genetic information.

▪ ***Others Involved in Your Health Care***

Using our best judgment, we may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law.

If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

Uses and Disclosures of Your PHI that Require Your Authorization

Sale of PHI

We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing

We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes

We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

Required Disclosures of Your PHI

The following is a description of disclosures that we are required by law to make.

▪ ***Disclosures to the Secretary of the U.S. Department of Health and Human Services***

We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

▪ ***Disclosures to You***

We are required to disclose to you most of your PHI in a “designated record set” when you request access to this information. Generally, a “designated record set” contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures

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of your PHI that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

We will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose PHI to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).

Even if you designate a personal representative, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.

▪ ***Business Associates***

We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management. Examples of our business associates would be our Third Party Administrator, Benefits Coordination Corporation which will be handling many of the functions in connection with the operation of our Group Health Plan; the retail pharmacy; and the mail order pharmacy.

▪ ***Other Covered Entities***

We may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

▪ ***Plan Sponsor***

We may disclose your PHI to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

Potential Impact of State Law

The HIPAA Privacy Rule regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

YOUR RIGHTS

The following is a description of your rights with respect to your PHI.

- ***Right to Request a Restriction***

You have the right to request a restriction on the PHI we use or disclose about you for payment or health care operations. *We are not required to agree to any restriction that you may request.* If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you. You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for restriction to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

- ***Right to Request Confidential Communications***

If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

You may request a restriction by contacting the designated contact listed on the first page of this Notice. It is important that you direct your request for confidential communications to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate your PHI with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger.

We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your PHI could endanger you. As permitted by the

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HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (*e.g.*, an Explanation of Benefits, or "EOB"). *Unless* you have made other payment arrangements, the EOB (in which your PHI might be included) will be released to the plan participant.

Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within two business days.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI might be disclosed (such as through an EOB). Therefore, it is extremely important that you contact the designated contact listed on the first page of this Notice as soon as you determine that you need to restrict disclosures of your PHI.

If you terminate your request for confidential communications, the restriction will be removed for *all* your PHI that we hold, including PHI that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your PHI will endanger you.

▪ ***Right to Inspect and Copy***

You have the right to inspect and copy your PHI that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy your PHI that is contained in a designated record set, you must submit your request to the designated contact listed on the first page of this Notice. It is important that you contact the designated contact to request an inspection and copying so that we can begin to process your request. Requests sent to persons, offices, other than the designated contact might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact the designated contact listed on the first page of this Notice. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

▪ ***Right to Amend***

If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by contacting the designated contact listed on the first page of this Notice. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to the designated contact so that we can begin to process your request. Requests sent to persons or offices, other than the designated contact might delay processing the request.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

▪ ***Right of an Accounting***

You have a right to an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing to the designated contact listed on the first page of this Notice. It is important that you direct your request for an accounting to the designated contact so that we can begin to process your request. Requests sent to persons or offices other than the designated contact might delay processing the request.

Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

▪ ***Right to a Copy of This Notice***

You have the right to request a copy of this Notice at any time by contacting the designated contact listed on the first page of this Notice. If you receive this Notice on our Website or by electronic mail, you also are entitled to request a paper copy of this Notice.

COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at the number listed on the first page of this Notice. A copy of a complaint form is available from this contact office.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize or any other way retaliate against you for filing a complaint with the Secretary or with us.

[END]

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

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2013. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	COLORADO – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	FLORIDA – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
	GEORGIA – Medicaid
	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150

<p align="center">IDAHO – Medicaid and CHIP</p> <p>Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588</p>	<p align="center">MONTANA – Medicaid</p> <p>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084</p>
<p align="center">INDIANA – Medicaid</p> <p>Website: http://www.in.gov/fssa Phone: 1-800-889-9949</p>	<p align="center">NEBRASKA – Medicaid</p> <p>Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278</p>
<p align="center">IOWA – Medicaid</p> <p>Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562</p>	<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900</p>
<p align="center">KANSAS – Medicaid</p> <p>Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884</p>	
<p align="center">KENTUCKY – Medicaid</p> <p>Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218</p>
<p align="center">LOUISIANA – Medicaid</p> <p>Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447</p>	<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710</p>
<p align="center">MAINE – Medicaid</p> <p>Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741</p>	
<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629</p>	<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100</p>
<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604</p>

<p>OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>UTAH – Medicaid and CHIP</p> <p>Website: http://health.utah.gov/upp Phone: 1-866-435-7414</p>
<p>OREGON – Medicaid and CHIP</p> <p>Website: http://www.oregonhealthykids.gov http://www.hijosaludablesoregon.gov Phone: 1-800-699-9075</p>	<p>VERMONT– Medicaid</p> <p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>
<p>PENNSYLVANIA – Medicaid</p> <p>Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462</p>	<p>VIRGINIA – Medicaid and CHIP</p> <p>Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647</p>
<p>RHODE ISLAND – Medicaid</p> <p>Website: www.ohhs.ri.gov Phone: 401-462-5300</p>	<p>WASHINGTON – Medicaid</p> <p>Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473</p>
<p>SOUTH CAROLINA – Medicaid</p> <p>Website: http://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p>WEST VIRGINIA – Medicaid</p> <p>Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability</p>
<p>SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>	<p>WISCONSIN – Medicaid</p> <p>Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002</p>
<p>TEXAS – Medicaid</p> <p>Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493</p>	<p>WYOMING – Medicaid</p> <p>Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531</p>

To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

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

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

Patient Protection Model Disclosure

When applicable, it is important that individuals enrolled in a plan or health insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights when applicable. The notice must be provided whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. This notice must be provided no later than the first day of the first plan year beginning on or after September 23, 2010.

The following model language can be used to satisfy the notice requirement:

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

CalPERS health plans generally allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the health plan network and who is available to accept you or your family members. Until you make this designation, the health plan or health insurance issuer will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the health plan at <http://www.calpers.ca.gov/index.jsp?bc=/member/health/edu/plans-online.xml>.

For plans and issuers that require or allow for the designation of a primary care provider for a child, add:

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

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add:

You do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health plan at <http://www.calpers.ca.gov/index.jsp?bc=/member/health/edu/plans-online.xml>.