CITY OF ONTARIO

2016 Benefits Summary Guide

For Executives & Elected Officials

CITY OF ONTARIO

APPROACH TO PUBLIC SERVICE

Choose public service to make a positive impact on the community.

- Be Committed to the Community.
- Achieve Excellence Through Teamwork.
- Do the Right Thing the Right Way.

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Benefits Plan Year 2016

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This benefits booklet is a summary only. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to your insurance company's Evidence of Coverage. The Evidence of Coverage is the binding document between the health plan and its members. If there are any discrepancies between the benefits in this booklet and the Evidence of Coverage, the Evidence of Coverage will prevail. You may also contact your insurance carrier with questions.

A Message from the City of Ontario

At the City of Ontario we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each and every employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all of our employees. This brochure will help you learn about and choose the type of plan and level of coverage that is right for you.

MEDICAL

Choosing the right health plan is probably one of the most important decisions you can make for you and your family. It is our objective to provide an employee benefit program with a high level of benefits making it easy for you and your dependents to access the medical care you need. Please carefully consider the plan information provided in this document to make the best medical choices for you and your family. Always remember to eat right and get plenty of exercise to feel your best! For 2016 the City provides $1,300 per month towards medical coverage and offers eleven plan choices. (In addition, for San Diego residents only, a Sharp HMO plan is also available).

PRESCRIPTION DRUGS

When you enroll in a medical plan, you and your eligible, enrolled dependents automatically receive prescription drug coverage. Generic drugs are the least expensive and have the same active chemical ingredients and therapeutic effect as their brand -name equivalents.

DENTAL

Our dental plan makes dental care more affordable for employees and their families. Remember to choose a dentist contracted with our plan for the biggest dental benefit. Taking care of your mouth, teeth and gums is a big part of making sure you feel your best. Healthy habits like brushing, flossing and seeing your dentist for regular cleanings help prevent problems. In 2016 the City contribution is up to $124.40 per month towards coverage if elected. You have three plan choices.

VISION

Eye doctors detect problems in vision, overall eye health, and detect signs of other health conditions like diabetic eye disease, high blood pressure and high cholesterol. We know your eye sight is precious to you and so we provide vision benefits to make sure your trip to the eye doctor is reasonably priced. The 2016 City contribution is $125.99, if elected.

LIFE AND AD&D

Life/Accidental Death & Dismemberment protects employees and their families from financial hardship in the event of death or dismemberment. It provides the peace of mind you get when you know your loved ones will be protected if anything happens to you. The City provides $106,000 Basic Life Insurance and $109,000 Accidental Death & Dismemberment (AD&D) coverage.

DISABILITY (*for Executives Only)*

One of the most important assets to you as an employee is the ability to earn an income. The Short and Long Term disability programs (STD/LTD), are designed to continue providing you with income if you're unable to work due to sickness or injury. Disability insurance can help you continue to pay your bills by replacing a portion of your income until you are able to return to work.

STD: City pays the premium for 66 2/3% of salary up to $3,461.54 per week.

LTD: City pays 100% of the premium for your LTD benefit. Your maximum monthly benefit will be $15,000.

RETIREMENT

A generous retirement plan is provided through the California Public Employees Retirement System (CalPERS), pursuant to the California Public Employees' Pension Reform Act (PEPRA) of 2013. The retirement formula for new CalPERS members is 2% at 62.

The retirement formula for individuals who became CalPERS members or are members of a reciprocal retirement plan before January 1, 2013 is 2.5% at 55. This formula applies to City of Ontario employees in full-time positions prior to the date above as well as current CalPERS members or members of reciprocal public sector retirement plans who begin employment with the City within six months of separating from another CalPERS or a reciprocal member agency.

The City of Ontario participates in Social Security The employee pays a required retirement contribution of 6.25% of their applicable compensation. Please contact the Human Resources Department for any questions regarding retirement.

401(a) & 457(b) DEFERRED COMPENSATION PROGRAM

Although the City provides a rich retirement plan through CalPERS, additional savings is required to maintain pre-retirement standard of living through the retirement years. 457(b) Deferred Compensation is a governmental plan for retirement saving that allows employees to supplement any existing retirement and pension benefits by saving/investing pre-tax dollars through a voluntary salary contribution. Contributions and any earnings on contributions are tax deferred until money is withdrawn. Distributions are subject to ordinary income tax. Executives receive a City contribution of 7.5% to a 401(a) plan (based on 26 pay periods). For elected Officials this depends on CalPERS Medical enrollment. Employees are also eligible to contribute to a 457(b) plan.

ANNUAL LEAVE 192 hours accrued in first year

***HOLIDAYS** Up to 13 paid holidays per year.

MANAGEMENT LEAVE Up to 40 hours per year.

EMPLOYEE ASSISTANCE PROGRAM

We recognize that personal problems are a normal part of living and that many employees will be affected by personal difficulties during the course of their career. The Employee Support Services (ESS) is an employer paid benefit providing you and eligible family members with confidential professional assistance. The ESS provides resources for mental and emotional well-being and can assist you and your family members with a variety of life's issues.

FLEXIBLE SPENDING ACCOUNTS

If you elect to participate in the Flexible Spending Accounts, you can set aside tax-free dollars each year to cover your eligible out-of-pocket expenses and daycare expenses.

ADDITIONAL BENEFITS

Ontario Public Employees Credit Union
www.opefcu.org

* *See Executives/Elected Officials' Memorandum of Understanding (MOU) for more specific details regarding these benefits.*

Enrollment for Executives & Elected Officials

Welcome to your Benefit Guide for Plan Year 2016! 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, 2016.

Please visit www.ontariocityemployees.org. Here 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 each benefit 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 14th 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 9, 2015.

MEDICAL

The City contracts with CalPERS for medical coverage. CalPERS offers a choice of up to eleven plans total, eight HMO and three PPO The HMO plan options are two Anthem plans, two Health Net plans, two Blue Shield plans, United Healthcare, and Kaiser. The three PPO plans are Anthem Blue Cross plans, PERS Choice, PERS Select and PERSChoice.

On July 1st, CalPERS launched a new website (www.calpers.ca.gov), to better serve its members, employers, and stakeholders. The site features multiple improvements including a new interface, upgraded search capability, and compatibility with mobile devices.

Additional website improvements include more pathways to popular destinations, and a life events area that focuses on what CalPERS members need to know during different stages of their career. The new look website offers a new approach to presenting information, resulting in less content delivered in a more effective way. Video and social media are also key components in the site's new structure.

DENTAL & VISION

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

Your Executive Vision plan is provided by Vision Service Plan (VSP).

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 visit www.ci.ontario.ca.us for full schedule of meeting dates, times and locations.

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

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 and/or January 1st for elections made during open enrollment. You will have 30 days from the date of hire to enroll. If you are hired on the first day of the month, you are 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
  - ⇒ Under the age of 23 to qualify for Life insurance
- 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.

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

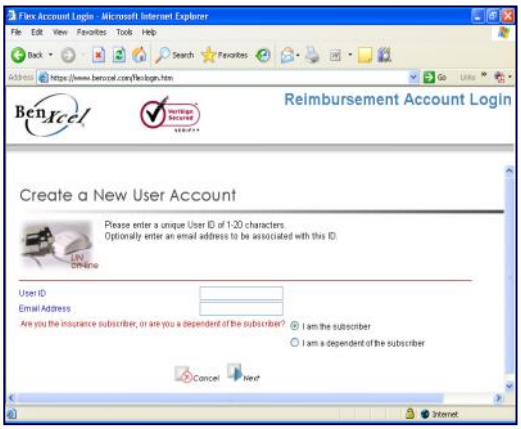
REMINDER: When enrolling or confirming your medical plan in the Benxcel system, medical plan rates and the health allotment provided to you by the City will not be displayed. This is due to the Zip Code eligibility rule and the regional pricing with the CalPERS medical plans. Please refer to your bargaining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

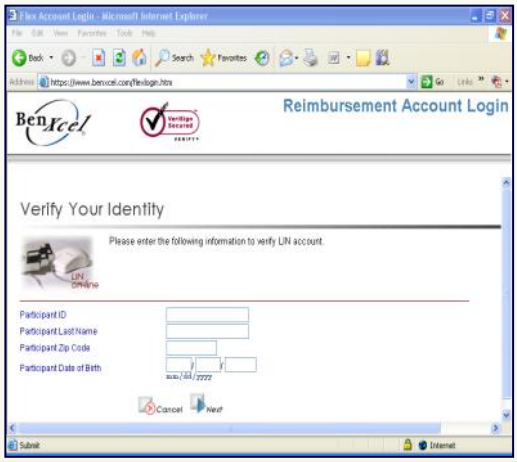
2. Create an account



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"

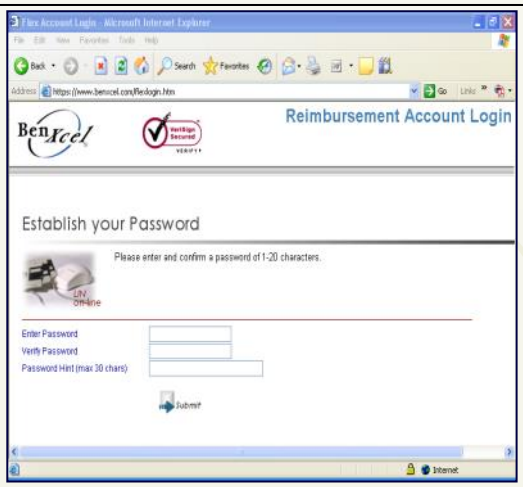
3. Verification



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 2016

CalPERS Medical Plan Availability

As an active employee you may enroll in a medical plan using either your residential or work zip code. A P.O. Box can only be used for mailing purposes and not for establishing eligibility.

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 and/or 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. This is required each Open Enrollment.**

Choosing Generic vs. Brand Name Drugs

When you request Brand Name Drugs over Generic, 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 contribution limit beginning in 2016 is to be $2,550, marking an increase of $50. Over-the-counter medications or supplies **are not eligible** for reimbursement.

New features include a rollover option of $500 from calendar year 2016 to calendar year 2017. In addition a debit card will be made available for employees to make purchases directly at point of sale merchants for their health care expenses. Dependent Care account maximum has not changed and will remain at $5,000 in 2016.

REMINDER: YOUR 2015 FLEXIBLE SPENDING ELECTION AMOUNTS WILL NOT "ROLLOVER" TO 2016. You must actively elect and designate an amount during each open enrollment to have FSA for the following calendar year.

Rules for Benefit Changes During the Plan Year

NOTE: 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.

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; or 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

Rules for Benefit Changes During the Plan Year

- 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:

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

Choosing the right health plan is probably one of the most important decisions you can make for you and your family. What's important to you – cost, provider choice, convenience?

Considerations When Making Your Medical Plan Decision

Carefully review all medical options made available for you and your family members. Variables that often impact your selection may include your dependent's health, expected medical costs, cost of the choices and anticipated family changes. In deciding on a medical option, consider the following:

- Are your current doctors in the plan network? You'll receive a higher level of benefits by visiting a network physician or facility.
- How often do you plan to use your medical benefits during the year? Some plans make sense if you require extensive medical care throughout the year or have a longstanding relationship with a non-network provider. Others may be more cost effective with lower out-of-pocket costs if you only need routine care during the year.
- What are the out-of-pocket costs associated with each plan? Keep in mind that depending on the plan, you may have a copay for doctor's office visits or an annual deductible before the plan starts paying any benefits.

You can refer to the medical plan comparison charts for a snapshot on commonly used benefits and refer to the plan benefit summary or plan document for details on specific benefits.

In a **Preferred Provider Organization** (PPO), there are two kinds of providers. One is known as a *preferred provider* who provides their services at a negotiated discounted rate and is therefore considered "in-network." In a PPO plan, you may also see a provider that is considered "out-of-network." In most cases, when you see an *out-of-network provider*, your care will still be covered, although not at the in-network negotiated discount rate.

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

In a **Health Maintenance Organization** (HMO), you must designate a Primary Care Physician (PCP) for routine care and/or referral to a specialist. If you use a provider that is not in the HMO, or if you receive care from a specialist without a referral from your PCP, you may have to pay the full cost of those services. Out-of-pocket costs are generally lower as long as your PCP coordinates all of your care.

Prescription Drug Coverage

When you enroll in a medical plan, you and your eligible dependents automatically receive prescription drug coverage.

Generic, Preferred/Formulary Brand Name, & Non-Preferred/Non-Formulary Brand Name Drugs

The medical plans provide coverage of prescription drugs at various levels:

Generic drugs have the same active chemical ingredients and therapeutic effect as their brand-name equivalents. Though they may vary in color and shape, the Food & Drug Administration requires that they meet the same quality standards as the brand name drug. These drugs require the lowest copay.

Preferred/Non-Preferred Brand drugs are defined by each plan. This program minimizes the prescribing of specific higher-cost, lower-value prescription drugs (non-preferred medications) and redirects those prescriptions to more cost effective medications (preferred medications). Typically, these drugs require higher copay than their generic equivalent.

Non-Preferred/Non-Formulary Brand drugs are not on the preferred/formulary drug list. Some plans may cover non-preferred/non-formulary brand drugs. If your plan covers these drugs, and you and your physician agree that you should have a non-preferred/non-formulary brand drug, your copay will be higher than that of the other drugs.

If you are taking an injectable drug make sure to consider the benefit differences under each plan to make the best choice for your needs.

Terms You Should Know

1. **Deductible**–This is the amount you must pay each calendar year before the plan begins to pay for certain benefits.
2. **Co-payment (copay)**–This is the fee that you must pay under your plan each time you go to a doctor or hospital for certain services. A copay is also required for prescription drugs.
3. **Co-Insurance**–This is the percentage of cost that you share with the plan provider after you have met the deductible.
4. **Out-of-Pocket Maximum**–The plan limits the amount of money that you will have to pay each year for covered expenses. Once you reach this dollar limit, the plan generally pays 100% of eligible expenses for the rest of the calendar year, up to the lifetime maximum.
5. **Usual, Customary and Reasonable (UCR)**–PPO plans pay up to a reasonable and customary amount for out-of-network services. Participants will have to pay for any expenses over the reasonable and customary amount, as determined by the insurance provider. Amounts over usual and customary do not apply to your deductible or out-of-pocket calendar year maximum.

Loss of Benefits

The following circumstances may result in disqualification, or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or dependent might otherwise reasonably expect the Plan to provide:

- an employee's cessation of active service for the employer;
- a participant's failure to pay his/her share of the cost of coverage, if any, in a timely manner;
- a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces the employee);
- a participant or dependent is injured by a third party, and expenses for treatment may be paid by or recovered from the third party or its insurer; or
- a claim for benefits is not filed within the Plan's applicable time limits.

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.

CalPERS Open Enrollment — Things You Need To Know

CalPERS Health Open Enrollment 2015
Starts September 14 and ends October 9

Things you need to know...

Even if you don't plan to make changes to your current coverage, aspects of your coverage may change. Educating yourself ensures you won't be surprised with potential cost or coverage changes and that you will be satisfied with your choice.

Your plan

Is your plan still available or is there a better option for you?

Your cost

Has your cost changed since last year?

Your network

Will you still have access to your doctors and/or hospitals?

You can find the information you need in your Open Enrollment packet, online at **www.calpers.ca.gov**, or by contacting your Health Benefits Officer or Human Resources Department.

FAQs about Open Enrollment

When can I make changes to my health care plan?
For the majority of members, the only time you can make changes is during CalPERS annual Open Enrollment period (starts September 14 and ends October 9). The only exceptions are when you qualify for Medicare, if you move, or when you retire.

When do changes take effect?
Any changes you request will take effect January 1, 2016.

Where can I find Open Enrollment information?
Your Open Enrollment packet, in conjunction with the CalPERS website at **www.calpers.ca.gov**, provides you access to everything you need to make an informed decision about your health care coverage. This includes: plan changes, lists of health plan costs, online publications, and where to find other important information. Additional questions? Your Health Benefits Officer or Human Resources Department is another great resource.

CalPERS

CalPERS Medical Rates — 2016 Employee Rates/Cost

Executives & Elected Officials

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

Waiving Medical					
Coverage Tier	*Total Premium*	*City Contribution*	*Employee Cost*		
Employee	$ -	$ 1,300.00	$ (1,300.00)		
Anthem HMO Select					
Coverage Tier	*Total Premium*	*City Contribution*	*Employee Cost*	*2015 Cost*	*Difference*
Employee	$ 543.47	$ 1,300.00	$ (756.53)	$ (646.60)	$ 109.93
Employee + One	$ 1,086.94	$ 1,300.00	$ (213.06)	$ (153.20)	$ 59.86
Employee + Family	$ 1,413.02	$ 1,300.00	$ 113.02	$ 142.84	$ 29.82
Anthem HMO Traditional					
Coverage Tier	*Total Premium*	*City Contribution*	*Employee Cost*	*2015 Cost*	*Difference*
Employee	$ 610.64	$ 1,300.00	$ (689.36)	$ (508.38)	$ 180.98
Employee + One	$ 1,221.28	$ 1,300.00	$ (78.72)	$ 123.24	$ 201.96
Employee + Family	$ 1,587.66	$ 1,300.00	$ 287.66	$ 502.21	$ 214.55
Health Net Salud y Mas					
Coverage Tier	*Total Premium*	*City Contribution*	*Employee Cost*	*2015 Cost*	*Difference*
Employee	$ 466.11	$ 1,300.00	$ (833.89)	$ (709.29)	$ 124.60
Employee + One	$ 932.22	$ 1,300.00	$ (367.78)	$ (278.58)	$ 89.20
Employee + Family	$ 1,211.89	$ 1,300.00	$ (88.11)	$ (20.15)	$ 67.96
Health Net SmartCare					
Coverage Tier	*Total Premium*	*City Contribution*	*Employee Cost*	*2015 Cost*	*Difference*
Employee	$ 585.39	$ 1,300.00	$ (714.61)	$ (571.53)	$ 143.08
Employee + One	$ 1,170.78	$ 1,300.00	$ (129.22)	$ (3.06)	$ 126.16
Employee + Family	$ 1,522.01	$ 1,300.00	$ 222.01	$ 338.02	$ 116.01
United Healthcare					
Coverage Tier	*Total Premium*	*City Contribution*	*Employee Cost*	*2015 Cost*	*Difference*
Employee	$ 492.24	$ 1,300.00	$ (807.76)	$ (681.26)	$ 126.50
Employee + One	$ 984.48	$ 1,300.00	$ (315.52)	$ (222.52)	$ 93.00
Employee + Family	$ 1,279.82	$ 1,300.00	$ (20.18)	$ 52.72	$ 72.90
Blue Shield Access + HMO					
Coverage Tier	*Total Premium*	*City Contribution*	*Employee Cost*	*2015 Cost*	*Difference*
Employee	$ 566.53	$ 1,300.00	$ (733.47)	$ (622.13)	$ 111.34
Employee + One	$ 1,133.06	$ 1,300.00	$ (166.94)	$ (104.26)	$ 62.68
Employee + Family	$ 1,472.98	$ 1,300.00	$ 172.98	$ 206.46	$ 33.48
BlueShield NetValue					
Coverage Tier	*Total Premium*	*City Contribution*	*Employee Cost*	*2015 Cost*	*Difference*
Employee	$ 576.46	$ 1,300.00	$ (723.54)	$ (654.59)	$ 68.95
Employee + One	$ 1,152.92	$ 1,300.00	$ (147.08)	$ (169.18)	$ (22.10)
Employee + Family	$ 1,498.80	$ 1,300.00	$ 198.80	$ 122.07	$ (76.73)
Kaiser HMO					
Coverage Tier	*Total Premium*	*City Contribution*	*Employee Cost*	*2015 Cost*	*Difference*
Employee	$ 543.83	$ 1,300.00	$ (756.17)	$ (618.82)	$ 137.35
Employee + One	$ 1,087.66	$ 1,300.00	$ (212.34)	$ (97.64)	$ 114.70
Employee + Family	$ 1,413.96	$ 1,300.00	$ 113.96	$ 215.07	$ 101.11
PERS Choice					
Coverage Tier	*Total Premium*	*City Contribution*	*Employee Cost*	*2015 Cost*	*Difference*
Employee	$ 598.75	$ 1,300.00	$ (701.25)	$ 554.82	$1,256.07
Employee + One	$ 1,197.50	$ 1,300.00	$ (102.50)	$ 30.36	$ 132.86
Employee + Family	$ 1,556.75	$ 1,300.00	$ 256.75	$ 381.47	$ 124.72
PERS Select					
Coverage Tier	*Total Premium*	*City Contribution*	*Employee Cost*	*2015 Cost*	*Difference*
Employee	$ 547.55	$ 1,300.00	$ (752.45)	$ (563.51)	$ 188.94
Employee + One	$ 1,095.10	$ 1,300.00	$ (204.90)	$ 12.98	$ 217.88
Employee + Family	$ 1,423.63	$ 1,300.00	$ 123.63	$ 358.87	$ 235.24
PERS Care					
Coverage Tier	*Total Premium*	*City Contribution*	*Employee Cost*	*2015 Cost*	*Difference*
Employee	$ 666.91	$ 1,300.00	$ (633.09)	$ (492.89)	$ 140.20
Employee + One	$ 1,333.82	$ 1,300.00	$ 33.82	$ 154.22	$ 120.40
Employee + Family	$ 1,733.97	$ 1,300.00	$ 433.97	$ 542.49	$ 108.52

CalPERS Health Premiums — 2016 Regional HMO Contracting Agencies

Contracting Agencies HMO only							
BASIC	2015			2016			Percent Change (+/-)
	Single	2-Party	Family	Single	2-Party	Family	
Basic Premium Rates - Los Angeles Area							
Los Angeles, San Bernardino, and Ventura							
Anthem HMO Select	$493.40	$986.80	$1,282.84	$543.47	$1,086.94	$1,413.02	10.15%
Anthem HMO Traditional	$631.62	$1,263.24	$1,642.21	$610.64	$1,221.28	$1,587.66	-3.32%
Blue Shield Access+	$517.87	$1,035.74	$1,346.46	$566.53	$1,133.06	$1,472.98	9.40%
Blue Shield NetValue	$485.41	$970.82	$1,262.07	$576.46	$1,152.92	$1,498.80	18.76%
Health Net Salud y Mas	$430.71	$861.42	$119.85	$466.11	$932.22	$1,211.89	8.22%
Health Net SamrtCare	$568.47	$1,136.94	$1,478.05	$585.39	$1,170.78	$1,522.01	2.98%
Kaiser CA	$521.18	$1,042.36	$1,355.07	$543.83	$1,087.66	$1,413.96	4.35%
United Healthcare	$458.74	$917.48	$1,192.72	$492.24	$984.48	$1,279.82	7.30%
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	$653.97	$1,307.94	$1,700.32	$634.75	$1,269.50	$1,650.35	-2.94%
Anthem HMO Traditional	$743.12	$1,486.24	$1,932.11	$710.79	$1,421.58	$1,848.05	-4.35%
Blue Shield Access+	$598.66	$1,197.32	$1,556.52	$654.87	$1,309.74	$1,702.68	9.39%
Blue Shield NetValue	$561.09	$1,122.18	$1,458.83	$666.35	$1,332.70	$1,732.51	18.76%
Health Net Salud y Mas	$520.59	$1,041.18	$1,353.53	$535.98	$1,071.96	$1,393.55	2.96%
Health Net SamrtCare	$579.88	$1,159.76	$1,507.69	$596.98	$1,193.96	$1,552.15	2.95%
Kaiser CA	$579.80	$1,159.60	$1,507.48	$605.05	$1,210.10	$1,573.13	4.35%
Sharp	$564.57	$1,129.14	$1,467.88	$561.34	$1,122.68	$1,459.48	-0.57%
United Healthcare	$449.10	$898.20	$1,167.66	$493.99	987..98	$1,284.37	10.00%
Basic Premium Rates - Out of State							
Kaiser/Out of State	$922.78	$1,845.56	$2,399.23	$930.29	$1,860.58	$2,418.75	0.81%
Medicare	2015			2016			Percent Change (+/-)
	Single	2-Party	Family	Single	2-Party	Family	
Medicare Premium Rates - All Regions							
Anthem Blue Cross	$445.38	$890.76	$1,336.14				
Blue Shield	$352.63	$705.26	$1,057.89				
Health Net	$276.85	$553.70	$830.50				
Kaiser CA	$295.51	$591.02	$886.53	$297.23	$594.46	$891.69	0.59%
Kaiser Out of State	$390.47	$780.94	$1,171.41	$297.23	$594.46	$891.69	-23.88%
Sharp	$327.66	$655.32	$982.98				
United Healthcare	$267.41	$534.82	$802.23	$320.98	$641.96	$962.94	

CalPERS Health Premiums — 2016 Regional PPO Contracting Agencies

Contracting Agencies PPO only - Basic Rates

Basic Premium Rates - Los Angeles Area							
Los Angeles, San Bernardino, and Ventura							
BASIC	2015			2016			Percent Change (+/-)
	Single	2-Party	Family	Single	2-Party	Family	
PERS Choice	$585.18	$1,170.36	$1,521.47	$598.75	$1,197.50	$1,556.75	2.33%
PERS Select	$576.49	$1,152.98	$1,498.87	$547.55	$1,095.10	$1,423.63	-5.02%
PERSCare	$647.11	$1,294.22	$1,682.49	$666.91	$1,333.82	$1,733.97	3.06%

Basic Premium Rates - Other Southern California							
Fresno, Imperial, Inyo, Kern, Kings, Madera, Riverside, Orange, San Diego, San Luis Obispo, Santa Barbara, and Tulare							
BASIC	2015			2016			Percent Change (+/-)
	Single	2-Party	Family	Single	2-Party	Family	
PERS Choice	$594.40	$188.80	$1,545.44	$683.71	$1,367.42	$1,777.65	15.03%
PERS Select	$585.58	$171.18	$1,522.51	$625.20	$1,250.40	$1,625.52	6.77%
PERSCare	$657.32	$1,314.64	$1,709.03	$761.50	$1,523.00	$1,979.91	15.85%

Basic Premium Rates - Out of State							
PERS Choice	$653.58	$1,307.16	$1,699.31	$625.31	$1,250.62	$1,625.81	-4.33%
PERSCare	$722.74	$1,445.48	$1,879.12	$696.49	$1,392.98	$1,810.87	-3.63%

Medicare Premium Rates - All Regions							
MEDICARE	2015			2016			Percent Change (+/-)
	Single	2-Party	Family	Single	2-Party	Family	
PERS Choice	$339.47	$678.94	$1,018.41	$366.38	$732.76	$1,099.14	7.93%
PERS Select	$339.47	$678.94	$1,018.41	$366.38	$732.76	$1,099.14	7.93%
PERSCare	$368.76	$737.52	$1,106.28	$408.04	$816.08	$1,224.12	10.65%

Delta Dental & Vision Service Plan — 2016 Rates/Cost

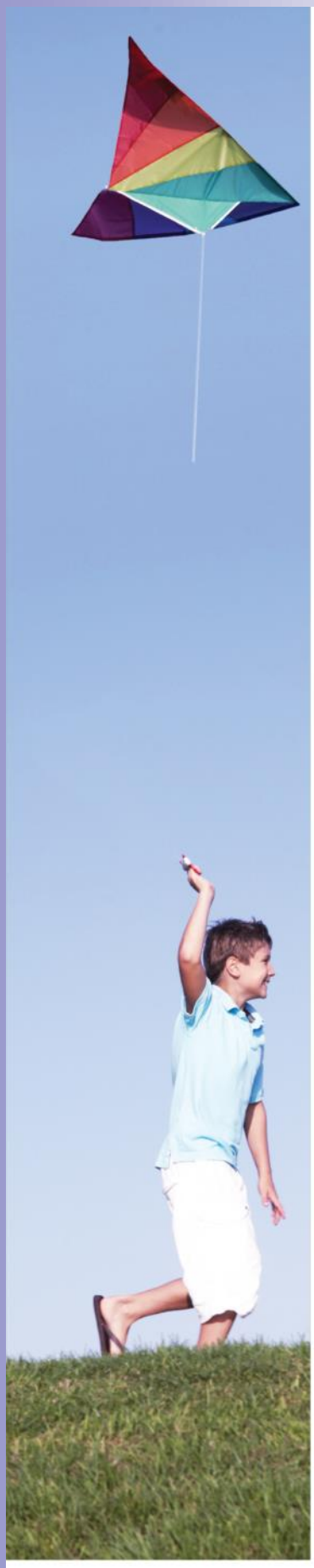
Executives & Elected Officials

DENTAL

Delta Dental PMI/DHMO			
Coverage Tier	*2016 Total Premium*	*City Contribution*	*Employee Cost*
Employee	$ 22.98	$ 22.98	$ -
Employee + One	$ 42.88	$ 42.88	$ -
Employee + Family	$ 64.32	$ 64.32	$ -
Delta Dental PPO			
Coverage Tier	*2016 Total Premium*	*City Contribution*	*Employee Cost*
Employee	$ 43.30	$ 43.30	$ -
Employee + One	$ 82.10	$ 82.10	$ -
Employee + Family	$ 124.40	$ 124.40	$ -
Delta Dental DPO Buy-Up			
Coverage Tier	*2016 Total Premium*	*City Contribution*	*Employee Cost*
Employee	$ 48.00	$ 43.30	$ 4.70
Employee + One	$ 85.30	$ 82.10	$ 3.20
Employee + Family	$ 129.20	$ 124.40	$ 4.80

EXECUTIVE VISION PLAN

Vision Service Plan (VSP)			
Coverage Tier	*2016 Total Premium*	*City Contribution*	*Employee Cost*
Employee	$ 125.99	$ 125.99	$ -
Employee + One	$ 125.99	$ 125.99	$ -
Employee + Family	$ 125.99	$ 125.99	$ -



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.com**[1] 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.

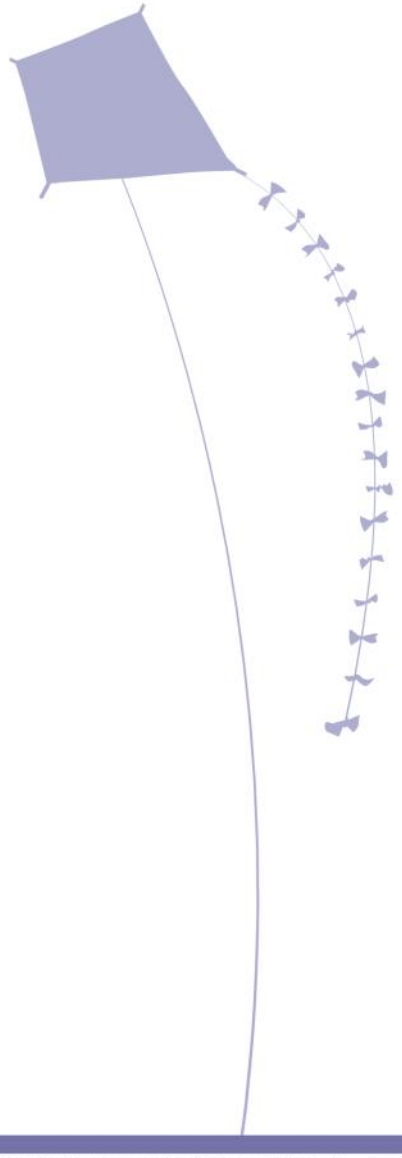
GET THE MOST FROM YOUR DELTACARE® USA PLAN

[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.

DELTA DENTAL®

WE KEEP YOU SMILING®



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

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EF17_DCU_USA #78015(rev. 6/14)

DELTA DENTAL PPO℠: YOUR SMILE IS COVERED

GO PPO!

You can visit any licensed dentist under this plan, but you'll maximize plan value by selecting a Delta Dental PPO[1] dentist. PPO network dentists have agreed to reduced contracted rates and can't "balance bill" you for additional fees.[2] Find a dentist at **deltadentalins.com**.[3]

CONVENIENT ONLINE SERVICES: DELTADENTALINS.COM

- Create a free Online Services account from your PC or smartphone to view benefits, eligibility and claims status or check average dental costs in your area.
- Update your dental benefit statement delivery preference: Go paperless!
- Find a Delta Dental PPO dentist near you.

NO ID CARD NECESSARY

Just provide your dental office with your name, birth date and enrollee ID or social security number. Register for Online Services to print an ID card or pull it up on your smartphone at the dentist's office.

HASSLE-FREE TRANSITION & EASY BENEFITS COORDINATION

New to Delta Dental PPO? This plan covers treatment started and completed after your plan's effective date of coverage.[4] If you're covered under two plans, ask your dentist to include information about both plans with your claim, and we'll handle the rest.

SAVE WITH A PPO DENTIST

DELTA DENTAL PPO

NON-DELTA DENTAL DENTISTS

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

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

[2] Enrollees are responsible for any coinsurance, deductible, amount over the plan maximum and charges for non-covered services.

[3] Verify that your dentist is a contracted Delta Dental PPO network dentist before each appointment.

[4] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier will be responsible for any costs. Group- and state-specific exceptions may apply. Enrollees currently undergoing active orthodontic treatment may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

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DELTA DENTAL®

WE KEEP YOU SMILING®

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

Group No: 16105 **Effective Date:** 01/01/2015

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the month dependent turns age 26			
Deductibles	PPO-Dentist: $10 per person/ $30 per family each calendar year Non-PPO Dentists: $25 per person/ $75 per family each calendar year			
Deductibles waived for Diagnostic, Preventive and Orthodontics?	Yes			
Maximums	$1,000 per person each calendar year			
Waiting Period(s)	Basic Benefits None	Major Benefits 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 and x-rays	100 %	100 %
Basic Services Fillings, simple tooth extractions and 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	60 %	50 %
Prosthodontics Bridges, dentures and implants	60 %	50 %
Orthodontic Benefits Dependent children	50 %	50 %
Orthodontic Maximum	$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

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.

HLT_PPO_2COL_DDC (Rev. 08/06/2014)

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

Group No: 16105 **Effective Date:** 01/01/2015

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the month dependent turns age 26			
Deductibles	PPO-Dentist: $10 per person/ $30 per family each calendar year Non-PPO Dentists: $25 per person/ $75 per family each calendar year			
Deductibles waived for Diagnostic, Preventive and Orthodontics?	Yes			
Maximums	$1,000 per person each calendar year			
D & P counts toward maximum?	No			
Waiting Period(s)	Basic Benefits None	Major Benefits 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 and x-rays	100 %	100 %
Basic Services Fillings, simple tooth extractions and 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	60 %	50 %
Prosthodontics Bridges, dentures and implants	60 %	50 %
Orthodontic Benefits Dependent children	50 %	50 %
Orthodontic Maximum	$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

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.

HLT_PPO_2COL_DDC (Rev. 08/06/2014)

Your VSP Vision Benefits

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

Using your VSP benefit is easy.

- Welcome to VSP Vision Care. We'll help keep you and your eyes healthy through personalized care from a doctor you can trust.
- Your eyes say a lot about you and can even tell your VSP doctor about you. During your WellVision Exam, your VSP doctor will look for vision problems and signs of health conditions too

Getting started is a breeze

Find the right VSP doctor for you. You'll find plenty to choose from at vsp.com or by calling **800.877.7195**

Already have a VSP Doctor? At your appointment, tell them you're a VSP member.

Check out your coverage and savings. Visit **vsp.com** to see your benefits anytime and check out how much you saved with VSP after your appointment.

That's it! We'll handle the rest - no ID card necessary or claim forms to complete.

Visit the Eyecare Discovery Center at vsp.com for eye health articles, videos, and interactive games.

Keep your eyes healthy and your vision clear with VSP.

Benefit	Description	Copay
Your eyecare benefit is brought to you by the *City of Ontario* and *VSP*.		
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	No Copay
Prescription Glasses		
Frame	• Frame of your choice covered in full every 12 months	No Copay
Lenses	• All lens options covered in full for employees and dependent children every 12 months	No Copay
	- OR -	
Contact Lens Care	• Contacts are covered in full in lieu of your spectacle lens and frame benefit AND • Second Pair - This enhancement allows you to obtain a second pair of glasses or contacts, in addition to those received under the core plan.	No Copay
Extra Savings	Glasses and Sunglasses • Average 35%-40% savings on all non-covered lens options • 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam. Contacts • 15% off cost of contact lens exam (fitting and evaluation) Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor	

VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

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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2016 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 2016 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.

DEBIT CARD FEATURE:

Shortly after enrolling in the Healthcare Flexible Spending Account (FSA), you will receive a FSA Debit Card to use for your eligible medical expenses. Your debit card will reflect the plan year contribution amount and the new effective date of the plan. As you incur expenses, use your FSA Debit Card to have the funds taken directly out of your account so you don't have to pay with cash out of your pocket.

CAUTION:

When estimating your annual expenses, consider only those that you are reasonably certain to incur. Any amount **over the $500 rollover 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.

The Maximum amount allowed for 2016 increases to $2,550.

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.

- To receive reimbursement from an FSA, you have to incur an expense during the time that you're covered by the FSA. An expense is incurred at the time you receive the health care or service. This is not when you're billed, or pay, for the expense. (The Schedule A deduction allows for expenses paid during the year.)
- Health insurance premiums and long-term care (LTC) premiums and care are not eligible FSA expenses. (The Schedule A deduction allows for premiums and LTC expenses.)
- Certain over-the-counter (OTC) health care items are eligible FSA expenses. However, you need a prescription for OTC drugs and medicines in order to receive reimbursement from the FSA. (The individual taxpayers income tax return does not allow a deduction for OTC items, drugs and medicines.)

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.

Employee Assistance Program

Employee Support Services (ESS) - The Counseling Team International offer confidential employee support services to all employees and eligible family members of the City of Ontario.

ESS are designed to help employees and their eligible family members with confidential professional assistance. The City of Ontario is committed to the health and well-being of our employees. We recognize that personal problems are a normal part of living and that many employees will be affected by personal difficulties during the course of their career.

ESS provides a variety of services to every employee and their eligible family members at no cost.

There are no fees for The Counseling Team International's counseling services. There are times when individuals are referred to resources outside the program. Should an employee or eligible family member decide to use these outside resources, they will be responsible for any fees associated with their use.

Call for an appointment! (909) 884-0133 or toll-free (800) 222-9691.

Visit the Counseling Team International's website for more information: www.thecounselingteam.com

You may seek help with many issues including the following:

- Marital & Family Problems
- Stress/Burnout
- Anger Management
- Separation/Divorce
- Child/Adolescent Issues
- Parenting Skills
- Suicide Prevention & Intervention
- Grief/Bereavement
- Depression
- Substance Abuse
- Retirement Concerns
- Career Concerns
- Critical Incident/Trauma
- Financial Issues
- Relationship Concerns
- Anxiety/ Panic Attacks

All counseling services are completely confidential unless the law requires divulgence. In addition, ESS provides website access to additional services and resources.

RIDESHARE PLUS PROGRAM

By ridesharing, you're helping to put the brakes on congestion and keep our skies blue. Rideshare Plus is your incentive for making the commitment to rideshare. To register for access to your one-year membership for an online savings site, powered by Entertainment.com, simply visit www.Rideshareplus.info and click on the Sign Up button. For registration questions, please contact 1-866-RIDESHARE. Rideshare Plus members have access to a coupon book for year-round savings from more than 135,000 merchants.

Dine. Shop. Save. Your Rideshare Plus program delivers big savings every day whether you're using your members' coupon book in the Inland Empire or on the go. Thanks again for ridesharing!

The Rideshare Plus program is a joint project funded by Riverside County Transportation Commission and San Bernardino Associated Governments.

CITY OF ONTARIO

2015 TOGETHER, CHANGING LIVES

GOALS

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:
Christine Lowe

View our latest financial statements on our website at www.ieuw.org.

GIVE WITH CONFIDENCE...

"...the most efficient charities spend 75% or more of their budget on their programs and services and less than 25% on fundraising and administrative fees."

- charitynavigator.org

87% community programs and nonprofit partners

10% fund raising

3% management

IEUW'S OVERHEAD IS HALF THAT!

FIND MORE INFORMATION AT
WWW.IEUW.ORG
SCAN THIS CODE TO VIEW OUR VIDEO AND LEARN MORE!

GIVE. ADVOCATE. VOLUNTEER.
LIVE UNITED

United Way
INLAND EMPIRE UNITED WAY

Obtaining Health Care Quality 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.

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

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your plan administrator. For more information on WHCRA benefits, call (909) 395-2433.

NEWBORN'S AND MOTHER'S 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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction

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

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

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.
- If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: City of Ontario Human Resources Department, 200 N. Cherry Avenue, Ontario, CA 91764.

How is COBRA continuation coverage provided?

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

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

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- Disability extension of 18-month period of COBRA continuation coverage

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

For more information about the Plan and COBRA continuation coverage, please contact Benefits at (909) 395-2433 or by email at benefits@ci.ontario.ca.us

IMPORTANT NOTICE FROM THE 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. City of Ontario has determined that the prescription drug coverage offered by the CalPERS Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the CalPERS Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from CalPERS. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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 decide to drop your current coverage with City of Ontario, since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under CalPERS.

Non-Creditable Coverage Notice

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

Since the coverage under CalPERS is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 entity's plan 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.

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

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

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 (1-800-633-4227). 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 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 14, 2015
Name of Entity/Sender:	City of Ontario
Contact--Position/Office:	Human Resources - Benefits
Address:	200 N. Cherry Ave., Ontario, CA 91764
Phone Number:	(909) 395-2433

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, 200 N. Cherry Ave., Ontario, CA 91764 or (909) 395-2433.

EFFECTIVE DATE

This Notice of Privacy Practices became 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;

- ***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.

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 previous 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 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 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.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2014. Contact your State for more 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	**FLORIDA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
ARIZONA – CHIP	**GEORGIA – Medicaid**
Website: http://www.azahcccs.gov/applicants http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid	**MONTANA – Medicaid**
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Website: http://medicaidprovider.mt.gov Phone: 1-800-694-3084

Mandated Notices

INDIANA – Medicaid

Website:
http://www.in.gov/fssa

Phone: 1-800-889-9949

IOWA – Medicaid

Website:
www.dhs.state.ia.us/hipp/

Phone: 1-888-346-9562

KANSAS – Medicaid

Website:
http://www.kdheks.gov/hcf/

Phone: 1-800-792-4884

KENTUCKY – Medicaid

Website:
http://chfs.ky.gov/dms/default.htm

Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website:
http://www.lahipp.dhh.louisiana.gov

Phone: 1-888-695-2447

MAINE – Medicaid

Website:
http://www.maine.gov/dhhs/ofi/public-assistance/index.html

Phone: 1-800-977-6740
TTY 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP

Website:
http://www.mass.gov/MassHealth

Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website:
http://www.dhs.state.mn.us/

Click on Health Care, then Medical Assistance

Phone: 1-800-657-3629

MISSOURI – Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

NEBRASKA – Medicaid

Website:
www.ACCESSNebraska.ne.gov

Phone: 1-800-383-4278

NEVADA – Medicaid

Medicaid Website:
http://dwss.nv.gov/

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website:
http://www.dhhs.nh.gov/oii/documents/hippapp.pdf

Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

Website:
http://www.nyhealth.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website:
http://www.ncdhhs.gov/dma

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/

Phone: 1-800-755-2604

To see if any other states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, 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, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

While every effort has been made to be as accurate as possible in developing the enclosed information, the official plan documents prevail in all cases. This is not a legal document. It is a brief summary of benefits and is not considered "Evidence of Coverage." Please refer to the policy/plan documents for a complete description of the controlling terms, coverages, exclusions, limitations and conditions of coverage. In case of any discrepancy between this information and the policy/plan documents, the policy/plan documents will prevail.

City of Ontario reserves the right to terminate, suspend, withdraw, or modify the benefits described in the policy/plan documents in whole or in part, at any time. No statement in this or any other document, and no oral representation should be construed as a waiver of this right. This summary is the confidential property of City of Ontario.

Notes

Your Benefits Carrier Contact Information

Benefit	*Carrier*	*Phone*	*Web*
Medical Coverage	CalPERS	888.225.7377	www.calpers.ca.gov
Dental Coverage	Delta Dental	800.765.6003	www.deltadentalins.com
Vision Coverage	Vision Service Plan	800.877.7195 or vsp.com	www.vsp.com
Life Insurance AD&D or Disability Claims	Cigna	1.800.36.24462 *7am-7pm Monday-Friday)*	www.cigna.com
Cigna Healthy Rewards® **Password: savings**	Cigna (password: savings)	1.800.258.3312	www.cigna.com/rewards
Identity Theft Services	Cigna Identy Theft Program #57	U.S.: 1.888.226.4567 Outside US: 202.331.7635	http://www.cigna.com/cignaproductlist/identity-theft-program
Will Preparation Program	Cigna	800.901.7534	www.CIGNAWillCenter.com
Section 125 Flexible Spending Account (FSA)	Benefit Coordinators Corporation (BCC)	412.276.1111	www.benXcel.com
Rideshare Plus Program		1-866-RIDESHARE or nsoto@sanbag.ca.gov	nsoto@sanbag.ca.gov
Ontario Public Employees Credit Union	202 West B Street Ontario, CA 91762	Tel: 909.984.8781 Fax: 909.984.4581	www.opefcu.org
Employee Assistance Program	Employee Support Services (ESS)	909.884.0133 or 800.222.9691	www.thecounselingteam.com

Contact your City of Ontario Human Resources Benefits Team at (909) 395-2433 for more information on the following benefits:

♦ **Flexible Spending Savings Account**	♦ **Healthcare & Dependent Care Reimbursement**
♦ **Annual Leave**	♦ **Retirement Benefits**
♦ **Management Leave**	♦ **Deferred Compensation Program**
♦ **Holidays**	