Employee Benefits Guide

2024

CITY OF OXNARD CALIFORNIA

Employee Benefits Guide 2024

General Information

Core Benefits

Other Benefits

Miscellaneous

Click this icon in your benefits guide to watch a video explaining the associated topic.
See page 72 for a glossary of terms.

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

Please see page 65 for more details.

The information in this brochure is a general outline of the benefits offered under the City of Oxnard's benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

Introduction

Each year Open Enrollment provides you an opportunity to change plans and modify dependent coverage. Your election deductions begin in January and will remain in effect through the plan year (January 1, 2024 – December 31, 2024) for all of your benefits.

NOTE: If your eligibility changes during the year you must notify Human Resources within 60 days of the qualifying event. A list of qualifying events can be found on page 9 in this guide.

Before you meet with your American Fidelity Representative, take time to evaluate your current coverage and decide how well it serves the needs of you and your family.

Important Dates to Remember

Your Open Enrollment Dates are:

September 18, 2023 - October 13, 2023

Your Plan Year is:

January 1, 2024 – December 31, 2024

Important Points To Consider

- Figure an estimate of out-of-pocket medical expenses. Remember that over-the-counter drugs and medicines now require a prescription to be reimbursed.
- Figure an estimate of child care expenses.
- Review your beneficiaries.
- Review American Fidelity's options of portable insurance plans that you can keep if your employment changes.
- Evaluate your need for life insurance.
- Consider increasing your Disability Income Insurance policy amount to match your current salary.

Introduction (continued)

Health insurance is one of the most critical benefits offered by the City of Oxnard. A major illness or injury could be financially devastating without adequate insurance. Even the cost of treatment of minor conditions can be prohibitive. With this in mind, the benefit program is designed exclusively to meet the health care needs of you and your family.

Depending on where you live, your personal preference regarding physician choice and type of health care environment you prefer, you may choose the plan that is most suitable for you and your family members.

The benefit choices you make when you and your dependent(s) enroll will remain in place for the calendar year unless your spouse or domestic partner experiences a loss in coverage, or you experience a change in family status (e.g., marriage, divorce, or legal separation, birth, adoption, death or spousal change). You will need to contact the Human Resources Department and return your enrollment forms within 60 days of your status change in order to enroll into medical coverage.

If you are a benefits-eligible employee, you may enroll or change your medical carrier/plan, as well as add any eligible dependents not previously enrolled under your coverage.

In order to enroll a spouse, you will need to provide a copy of your marriage license issued by the state or country in which you were married. To enroll a domestic partner, you will need to provide a copy of your declaration of domestic partnership certificate issued by the state in which your domestic partnership was entered. If you wish to enroll dependent children, a copy of the birth certificate issued by the state, adoption papers, or proof of legal guardianship is required.

Your dependents are defined as:

- Legally married spouse
- Registered domestic partner
- **Children to age 26:**
  - Natural
  - Step-children
  - Children of a registered domestic partner
  - Legally adopted
  - Disabled adult child over age 26.

As a City of Oxnard employees, you and your family are entitled to a number of benefits. This benefits guide contains information on all of the benefits you are entitled to as an employee of the City of Oxnard.

Important Notice

On June 26, 2013, the U.S. Supreme Court ruled that the federal ban on recognizing same-sex marriages was unconstitutional. As a result, same-sex married partners who reside in a state in which same-sex marriage is recognized are legally considered married and are to be treated the same as opposite-sex married partners in all respects under Federal and State law, which means they may now be eligible for benefits to which they were not previously entitled —for example, payment of health insurance premiums on a pre-tax basis, COBRA continuation rights, and other benefits for which spouses are eligible. Any legally married same sex partner should immediately review his or her employee benefits elections to ensure that he or she is maximizing what is now available to same sex marriage partners. The law has not changed with respect to same-sex domestic partners who are not married.

Introduction (continued)

Benefit Choices

The City recognizes that your benefits are an important part of the reason you choose to work here. The City provides high quality benefits at a reasonable cost to you. You can choose between different medical plans to meet your individual and family needs. Since you have some choices to make, it is important to understand the various programs. That is why this Guide is being provided for you. Benefits provided by the City for eligible employees include a choice of CalPERS medical plans, dental plans, vision plans, group life insurance coverage, group disability and optional voluntary benefits.

Benefits will begin the 1st of the month following the receipt of your enrollment by the Health Benefits Officer.

Any questions you may have regarding the enclosed information can be referred to the corresponding representative on the contact information sheet or the health benefits directory.

During open enrollment, if you are a benefit eligible employee, you may enroll or change your medical carrier/plan, as well as add any eligible dependents not previously enrolled under your coverage.

Contact Information

Employee Benefits Program	Benefits Representative	Contact Information
Risk & Benefits Administration	**Mike More** Human Resources Manager	805-385-7480 mike.more@oxnard.org
COBRA	**Sonia Rosales** Human Resources Technician	805-385-7473 Benefits@oxnard.org
	Yesenia Garcia Human Resources Technician	805-385-7481 Benefits@oxnard.org
• Medical	See Health Plan Directory on Page 12	
• Dental (PPO)	Delta Dental	800-632-8555 www.deltadentalins.com
• Dental (DHMO)	Cigna	800-244-6224 www.mycigna.com
Vision		
• EyeMed	The Standard	866-289-0614 www.standard.com/services
• VSP	The Standard	800-877-7195 www.standard.com/services
Flex Spending Accounts and Additional Insurances	American Fidelity	800-662-1113 www.americanfidelity.com
Life and Disability Insurance		
• Short Term Disability	The Standard	800-368-2859 Fax 800.378.6053
• Long Term Disability	The Standard	800-368-1135 Fax 800.378.6053
• Life Claims	The Standard	800-628-8600 Fax 971.321.6808
Employee Assistance Program	The Standard EAP	800-367-7474 www.mylifematters.com passcode: coe
Fair Employment & Housing Act (FEHA)	**Mike More** Human Resources Manager	805-385-7480 mike.more@oxnard.org
Workers Compensation	**Alex Juarez-Pina** Human Resources Analyst	805-385-7458 alex.juarez-pina@oxnard.org
Family Medical Leave Act (FMLA)	**Alex Juarez-Pina** Human Resources Analyst	805-385-7458 alex.juarez-pina@oxnard.org
Retirement *(CalPERS & Milliman/"PARS")*	**Sonia Rosales** Human Resources Technician	805-385-7473 Benefits@oxnard.org
Benefits Resources	**Sonia Rosales** Human Resources Technician	805-385-7473 Benefits@oxnard.org
	Yesenia Garcia Human Resources Technician	805-385-7481 Benefits@oxnard.org

Benefit Information can be located at:

www.benefitbridge.com/oxnard

Section 125 Cafeteria Plan

Save Money with a Section 125 Plan

If there was a program available that could dramatically save money on your taxes, would you take advantage of it? That's exactly what the Section 125 Plan does – reduces your taxes and increases your spendable income! Plus, the Plan is available to you at no cost and you're already eligible, all you have to do is enroll.

The Plan works like this: You are allowed to deduct needed benefits from gross earnings before taxes are computed. This means that current after-tax expenses, such as insurance products and benefits, can be paid for with pre-tax dollars.

The advantage of this Plan is simple: The eligible premiums you pay under the Plan are paid on a pre-tax basis. You could be on your way to increased savings, just by signing up and taking advantage of this Plan!

Benefits Eligible

- Group Medical, Dental and Vision Insurance
- Accident Insurance
- Cancer Insurance
- Child Care Expenses

How Can This Plan Help Me?

The sample paycheck below shows the benefits under the Section 125 Plan compared to benefits outside of the Plan. In this example, the employee gained $55 more spendable income per month!

Pre-Tax Example		After-Tax Example
$1,500	Monthly Gross Salary	$1,500
($150)	Pre-Tax Medical Insurance	$0.00
($25)	Pre-Tax Disability Insurance	$0.00
($2,500)	Pre-Tax Accident Insurance	$0.00
$1,300	Adjusted Monthly Gross Salary	$1,500
($260)	Estimated Federal Tax (20%)	($300)
($99)	Estimated FICA (7.65%)	($115)
$0.00	After-Tax Medical Insurance	($150)
$0.00	After-Tax Disability Insurance	($25)
$0.00	After-Tax Accident Insurance	($25)
$941	**TAKE-HOME PAY**	**$885**

Taxes are a sample average of State, Federal and FICA taxes. Your own average tax rate may vary.

See how to enroll on the next page!

How to Enroll

The City is providing every employee with an opportunity to understand their employee benefits, ask questions unique to their situation, and enroll in benefits. These include group meetings and one-on-one on-site enrollments. Your enrollment options will be as follows:

Option 1

Online Enrollment on BenefitBridge

Self enroll at www.benefitbridge.com/oxnard

You have the ability to make changes via BenefitBridge beginning Monday, September 18, 2023 through Friday, October 13, 2023. No changes will be allowed after this date.

Option 2

Make a Virtual Appointment

Speak to an American Fidelity representative virtually. This allows you the opportunity to ask unique questions regarding your benefit options in a virtual setting. Visit americanfidelity.com/pages/city-of-oxnard to schedule your enrollment.

Option 3

Enroll On-Site/One-on-One Benefit Review

On-site enrollment counselors will be available to assist you with the enrollment process. This allows you the opportunity to ask unique questions regarding your benefit options, in a confidential and private setting.

During your One-on-One Benefit Review, you can learn more about or enroll in the following:

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Group Life Insurance
- Term Life Insurance
- Disability Income Insurance
- Flexible Spending Accounts
- Cancer Insurance
- Accident Only Insurance
- Group Critical Illness

Eligibility and Enrollment

Who Is Eligible for the CalPERS Health Program?

Employees

Eligibility is based on tenure and time base of your qualifying appointment. You must work at least half-time and have a permanent appointment or a "limited term" appointment with a duration of more than six months. If you are a temporary or variable-hour employee, you may be eligible for health coverage due to new provisions in the Public Employee Medical and Hospital Care Act (PEMHCA) that help large contracting employers meet ACA requirements. To check if you meet the expanded eligibility criteria, contact your employer.

Family Members

The terms "family member" and "dependent" are used interchangeably. Eligible family members include:

- Spouse
- Registered domestic partner
- Children (natural, adopted, domestic partner's, or step) up to age 26
- Children, up to age 26, if the employee or annuitant has assumed a parent-child relationship and is considered the primary care parent
- Certified disabled dependent children age 26 and older

Who Is Not Eligible for the CalPERS Health Program?

Ineligible Employees

- Those working less than half time
- Those whose appointment lasts less than six months
- Those whose job classification is "Limited-Term/ Intermittent" (seasonal or temporary)
- Those classified as "Permanent-Intermittent" who do not meet the hour requirements within the control period

Ineligible Family Members

- Former spouses/former registered domestic partners
- Children age 26 and older
- Disabled children over age 26 who were never enrolled or who were deleted from coverage
- Children of a former spouse/former registered domestic partner
- Grandparents
- Parents

Do Not Enroll Ineligible Family Members

It is against the law to enroll ineligible family members. If you do so, CalPERS will retroactively cancel the enrollment and you may have to pay all costs incurred by the ineligible person from the date the coverage began.

Where to Get Help With Your Health Benefits Enrollment

If you are an active employee, please refer to BenefitBridge to make all health benefit enrollment changes. If you have additional questions you may contact your Health Benefits Officer located in your Human Resources Department

Once you retire, CalPERS becomes your Health Benefits Officer. As a retiree, you may make changes to your health plan in any of the following ways:

- **Online through my|CalPERS during Open Enrollment at:** my.calpers.ca.gov
- **By writing to CalPERS at:** P.O. Box 942715, Sacramento, CA 94229-2715
- **By calling CalPERS toll free at:** 888-CalPERS (or 888-225-7377).

For general information about health benefits, go to the CalPERS website at www.calpers.ca.gov.

* The Affordable Care Act has provisions which expand eligibility criteria for certain variable-hour employees. For additional information, please contact your employer.

Eligibility and Enrollment (continued)

Spouse

You may add your spouse to your health plan within 60 days of your marriage. You are required to provide a copy of the marriage certificate and the spouse's Social Security Number and Medicare card (if applicable). Your spouse's coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

Registered Domestic Partner

You may add your registered domestic partner to your health plan within 60 days of registration of the domestic partnership. The coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Enrollment Form.

To add a domestic partner to your health plan, you must register your domestic partnership through the California Secretary of State's Office or equivalent office from another state. Upon registration, that office will provide you with a Certificate of Registered Domestic Partnership.

CalPERS requires that you submit a copy of the Certificate of Registered Domestic Partnership and other information as may be required.

Two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring and who are not married to someone else or a member of another domestic partnership and not related by blood in a way that would prevent them from being married are eligible to register with the Secretary of State. For more information about domestic partnership registration, visit the Secretary of State's website at https://www.sos.ca.gov/registries/domestic-partners-registry/.

Children

Natural-born, adopted, domestic partners, and stepchildren who are under age 26 may be added to your health plan, as outlined below:

- Newborn children should be added within 60 days of birth. Coverage is effective from the date of birth.
- Newly adopted children should be added within 60 days of physical custody. Coverage is effective from the date physical custody is obtained.
- Stepchildren or a domestic partner's children under age 26 can be added within 60 days after the date of your marriage or registration of your domestic partnership. The coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

Disabled Children Over Age 26

A child age 26 and over who is incapable of self-support because of a mental or physical condition may be eligible for enrollment. The disability must have existed prior to reaching age 26 and continuously since age 26, as certified by a licensed physician. You are required to complete and submit the Member Questionnaire for the CalPERS Disabled Dependent Benefit form, and the physician must complete and submit a Medical Report for the CalPERS Disabled Dependent Benefit form for CalPERS approval. The initial certification of the Disabled Dependent must occur during one of the following two eligibility periods (whichever applies):

- Within 60 days before and ending 60 days after the child's 26th birthday (member and dependent currently enrolled), ***or***
- Within 60 days of a newly eligible employee's initial enrollment in the CalPERS Health Program

Upon certification of eligibility, the dependent's coverage must be continuous and without lapse. You will be required to submit an updated questionnaire and medical report for re-certification periodically, upon request.

Note: If the disabled child has a Social Security approved disability, you must provide CalPERS with a copy of his or her Medicare card.

Eligibility and Enrollment (continued)

Life Changes and Their Impact on Benefits

Outside of the annual open enrollment period, an employee may change an enrollment election (i.e., add or delete dependents, change level of coverage) only if there has been a "major life event."

Name or Address Changes

If you move or change your name or contact information for any reason, including Marriage or Divorce, you must change your name through your employer. That way you will receive all your benefit information in a timely manner.

Health Benefits Coverage

Since you must choose a CalPERS health plan that provides coverage in your work or home ZIP code, a change in your address could mean you have to change plans. You can use our Health Plan Search by ZIP Code on line service to see what plans are available in your new ZIP code.

Marriage

Retirement Impact – Your marriage revokes a designation you may have on file. In most instances, you must be married for at least one year prior to your retirement date for survivor benefits to be payable to your spouse. Review your beneficiary designation. If you need to make changes, log on to BenefitBridge and click on the "Life Events" button.

Health Benefits Coverage – Contact Human Resources as soon as possible to add your new spouse and any stepchildren to your health coverage. Your employer will need a copy of your marriage certificate and new spouse's Social Security number, as well as birth certificates and social security cards for step children.

CLICK HERE to watch a video on Qualifying Life Events

Divorce

Retirement Impact – Your CalPERS benefits are considered community property under California law. To see how this may impact your benefits, review Community Property (PUB38AI PDF) or CalPERS at 888-225-7377. Your dissolution of marriage revokes a designation you may currently have on file with CalPERS. Review your beneficiary designation. If you need to make changes, log in to your my CalPERS account to make changes online or complete the appropriate designation form.

To see how this may impact your benefits, review Community Property (PUB38AI PDF) or contact CalPERS at 888-225-7377.

Registered Domestic Partnership

To find out more about registering a domestic partner, visit the Secretary of State website.

Retirement Impact – Your domestic partnership revokes a designation you may have on file. Review your beneficiary designation. If you need to make changes, log on to BenefitBridge.

Eligibility and Enrollment (continued)

Additional Enrollment Opportunities

New employees and their dependents may initially enroll in a CalPERS health plan as indicated in the previous sections. Additional enrollment options and guidelines are described below.

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) to improve portability and continuity of health insurance coverage in the group insurance markets. HIPAA requirements for CalPERS took effect in 1998. HIPAA offers two provisions for employees and family members to enroll in CalPERS health plans outside of the initial enrollment period and the Open Enrollment period.

Special Enrollment

Special Enrollment refers to certain types of enrollment after your initial enrollment, but outside of the Open Enrollment period. You may need Special Enrollment under the following circumstances:

1. **You lose other health coverage:** If you initially declined (or canceled) enrollment for yourself or your dependents (including your spouse) because you had other private or CalPERS health coverage at that time, you may be able to enroll in a CalPERS health plan if the other coverage involuntarily ends. To qualify, you will need to request enrollment within 60 days after the other coverage ends and provide proof that the other coverage has ended.
2. **You have new family members:** When you enroll, you must enroll yourself or yourself and all eligible family members. If you later have a new dependent as a result of marriage, domestic partnership registration, birth, change of custody, adoption, or placement for adoption, you may enroll yourself and all eligible dependents within 60 days of that event.

The effective date for a Special Enrollment is the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

Late Enrollment

If you decline or cancel enrollment for yourself or your dependents and the Special Enrollment exceptions do not apply, your right to enroll (or add dependents) will be limited. You will either have to wait for a 90-day period or until the next CalPERS Open Enrollment period. The earliest effective date of enrollment will be the first of the month following the 90-day waiting period or the January 1 following the Open Enrollment period.

City of Oxnard Online Benefits Enrollment is easy with BenefitBridge!

Need Help?

For all questions related to your benefits, please contact your employer's benefits administrator. For BenefitBridge technical assistance ***only***, please contact BenefitBridge Customer Care at 800-814-1862; Mon – Fri, 8:00 a.m. – 5:00 p.m., PST or email benefitbridge@keenan.com.

Here's what you can do on BenefitBridge:

- View Current Plan Year Benefits
- Compare Plan Options
- Enroll in Benefits
- Resource Center: Health Insurance Basics, Medicare, Glossary, Media Resources
- Add or Remove Dependents/ Beneficiaries
- Message Center
- Update My Account Info
- Available 24/7 via the Internet

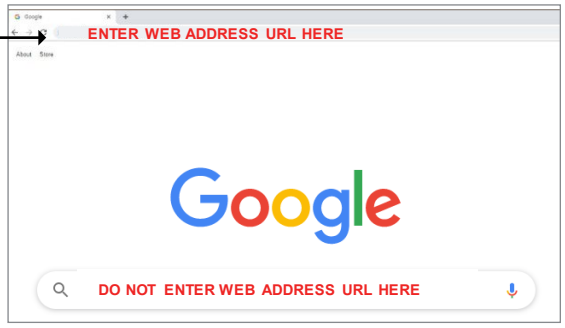
Registration and Login

Already have login credentials?

1. Login to **BenefitBridge** at www.benefitbridge.com/oxnard
2. Forgot your Username or Password? Click on **"Forgot Username/Password?"**
3. Please add or update your email address to receive an email confirmation of your enrollment approval.

Need to create login credentials?

1. In the **address bar**, type www.benefitbridge.com/oxnard **(Not in the Google, Yahoo, Bing, etc. search engine field)**
2. Click the **Enter** key, then follow the instructions below to register:
   - **STEP 1:** Select **"Register"** to **Create an Account**
     - **You will need to create an account using your first and last names as they appear on your payroll statement.**
   - **STEP 2:** Create a **Username** and **Password**
   - **STEP 3:** Select a picture, as instructed
   - **STEP 4:** Select **"Continue"** to access **BenefitBridge**



Enrolling in Benefits

Access your enrollment via the **"Make Changes to My Benefits"** button

For BenefitBridge technical assistance only, please contact BenefitBridge Customer Care at

800-814-1862

Monday – Friday, 8:00 AM - 5:00 PM, PST or email benefitbridge@keenan.com.

2024 Summary of Benefits and Coverage Notice

Choosing your health plan is an important decision. To assist you with this process, each health plan available through the California Public Employees' Retirement System has produced a Summary of Benefits and Coverage (SBC). In addition, the federal government has compiled a glossary of common health insurance terms. Together, these documents provide important information to help you better understand your health benefit coverage and more easily compare health plan options.

To access the SBCs and glossary online, visit www.calpers.ca.gov and select **View Health Plan Rates** to access the **Plans & Rates** page, or visit any of the health plan websites below. To request a free paper copy of the SBC and glossary, contact each health plan directly.

Anthem Blue Cross HMO & EPO
855-839-4524
www.anthem.com/ca/calpers

Blue Shield of California
800-334-5847
www.blueshieldca.com/calpers

California Association of Highway Patrolmen[1]
800-734-2247
www.thecahp.org

California Correctional Peace Officers Association[1]
800-257-6213
www.ccpoabtf.org

Health Net of California
888-926-4921
www.healthnet.com/calpers

Kaiser Permanente
800-464-4000
www.kp.org/calpers

Peace Officers Research Association of California[1]
800-288-6928
http://ibt.porac.org

PERS Gold and PERS Platinum
877-737-7776
www.anthem.com/ca/calpers

Sharp Health Plan
855-995-5004
www.sharphealthplan.com/calpers

UnitedHealthcare
877-359-3714
www.uhc.com/calpers

Western Health Advantage
888-942-7377
www.westernhealth.com/calpers

1 To enroll in these health plans, you must belong to the specific employee association and pay applicable dues.

Considering Your Health Plan Choices

The City of Oxnard offers several different medical plan options; Health Maintenance Organizations (HMO) or Preferred Provider Organizations (PPO) for all full-time employees and their eligible dependents through CalPERS.

Selecting a health plan for yourself and your family is one of the most important decisions you will make. This decision involves balancing the cost of each plan, along with other features, such as access to doctors and hospitals, pharmacy services, and special programs for managing specific medical conditions. Choosing the right plan ensures that you receive the health benefits and services that matter to you.

If you are a new CalPERS member or you are considering changing your health plan during Open Enrollment, you will need to make two related decisions:

- Which health plan is best for you and your family?
- Which doctors and hospitals do you want to provide your care?

The combination of health plan and providers that is right for you depends on a variety of factors, such as whether you prefer a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO); your premium and out-of-pocket costs; and whether you want to have access to specific doctors and hospitals.

We realize that comparing health plan benefits, features, and costs can be complicated. This section provides information that can simplify your decision making process. As you begin that process, the following are some questions you should ask:

- Do you prefer to receive your health care from an HMO or PPO? Your preference will impact the plans available to you, your access to health care providers, and how much you pay for certain services. See the chart on the next page for a summary of the differences among plan types[1].
- What are the costs (premiums, co-payments, deductibles, and coinsurance)?
- Does the plan provide access to the doctors and hospitals you want? Contact health plans directly for this information. See the "Health Plan Directory"

CLICK HERE to watch a video on Health Maintenance Organizations (HMO)

CLICK HERE to watch a video on Preferred Provider Organizations (PPO)

CLICK HERE to watch a video on PPO vs HMO

Understanding How CalPERS Health Plans Work

The following chart will help you understand some important differences among health plan types.

Features	HMO	PPO
Accessing health care providers	• Contracts with providers *(doctors, medical groups, hospitals, labs, pharmacies, etc.)* to provide you services at a fixed price	• Gives you access to a network of health care providers *(doctors, hospitals, labs, pharmacies, etc.)* known as preferred providers
Selecting a primary care physician (PCP)	• Most HMOs require you to select a PCP who will work with you to manage your health care needs[1]	• Does not require you to select a PCP
Seeing a specialist	• Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	• Allows you access to many types of services without receiving a referral or advance approval
Obtaining care	• Generally requires you to obtain care from providers who are a part of the plan network • Requires you to pay the total cost of services if you obtain care outside the HMO's provider network without a referral from the health plan *(except for emergency and urgent care services)*	• Encourages you to seek services from preferred providers to ensure your coinsurance and co-payments are counted toward your calendar year out-of-pocket maximums[2] • Allows you the option of seeing non-preferred providers, but requires you to pay a higher percentage of the bill[3]
Paying for services	• Requires you to make a small co-payment for most services	• Limits the amount preferred providers can charge you for services • Considers the PPO plan payment plus any deductibles and co-payments you make as payment in full for services rendered by a preferred provider

1. Your PCP may be part of a medical group that has contracted with the health plan to perform some functions, including treatment authorization, referrals to specialists, and initial grievance processing.
2. Once you meet your annual deductible and co-insurance, the plan pays 100 percent of medical claims for the remainder of the calendar year; however, you will continue to be responsible for co-payments for physician office visits, pharmacy, and other services, up to the annual out-of-pocket maximum.
3. Non-preferred providers have not contracted with the health plan; therefore, you will be responsible for paying any applicable member deductibles or coinsurance, plus any amount in excess of the allowed amount

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

2024 Premiums/Cafeteria

Two Level Medical Plan

During this Open Enrollment Period, existing employees hired before January 1, 2023 will need to choose between two levels of a medical cafeteria plan. Employees hired on or after January 1, 2023, are only eligible for **Level 2**.

Level 1 – Classic Plan

- Cafeteria Dollars for medical remain the same as 2023
  - $1,543 per month for employees that purchase a medical plan (employee continues to retain unused cash)
  - $1,243 per month ($900 for OPOA and OPSMA) for employees that waive coverage
- After January 1, 2023, Employees can remain in Level 1 for as long as they have no future changes to their medical.
- Any changes made after January 1, 2023, (e.g., change in family status, change in insurance carrier, change between waive/covered), will move an employee to Level 2.

Level 2 – Enhanced Plan

- Cafeteria Dollars for medical (Single, Single+1, Family) are adjusted annually over the term of the MOU (no cash back for using less than maximum amounts below)
  - **2024:** Up to $1,863 per month
  - **2025*:** Up to $1,956 per month
- Employees who waive coverage under Level 2 will receive $500 per month
- Any existing employee moving to Level 2 cannot move back to Level 1
- All new employees hired after January 1, 2023 will be enrolled in Level 2

* Except OPOA and OPSMA, whose contracts expire 06/30/2024

2024 Premiums/Cafeteria (continued)

2024 Premiums for Medical, Dental, and Vision

Biweekly Health Plan Premium Comparison							
		2023 Biweekly Deductions			2024 Biweekly Deductions		
		Single	2-Party	Family	Single	2-Party	Family
Medical HMO Plans	**Anthem Select HMO**	$283.56	$636.80	$848.75	$300.33	$673.12	$896.79
	Anthem Traditional HMO	$361.90	$793.50	$1,052.45	$404.94	$882.35	$1,168.80
	Blue Shield Access+	$319.20	$708.10	$941.44	$328.68	$729.82	$970.50
	Blue Shield Trio	$281.40	$636.50	$843.16	$301.50	$675.45	$899.82
	Kaiser Permanente	$279.33	$628.35	$837.76	$345.21	$762.88	$1,013.48
	United Healthcare Alliance	$296.60	$662.89	$882.66	$314.25	$700.97	$933.00
	HealthNet Salud y Mas *(LA County Residents Only)*	$252.88	$575.46	$769.00	$218.37	$509.20	$683.70
Medical PPO Plans	**PERS Platinum**	$398.68	$867.05	$1,217.76	$459.00	$990.46	$1,309.34
	PERS Gold	$251.51	$572.70	$835.12	$296.51	$665.48	$886.86
	PORAC *(Police Safety Only)*	$308.77	$691.85	$1,038.46	$354.92	$787.38	$1,021.85

Medical Cafeteria Dollars By Bargaining Unit	Level 1 Biweekly Cafeteria $	Level 1 Biweekly Waived $	Level 2 Biweekly Cafeteria $	Level 2 Biweekly Waive $
IAFF *(International Association of Fire Fighters)*	$712.15	$573.69	$859.85	$230.77
IUOE *(International Union of Operating Engineers)*	$712.15	$573.69	$859.85	$230.77
OMMA *(Oxnard Mid-Management Association)*	$712.15	$573.69	$859.85	$230.77
OPOA *(Oxnard Peace Officers Association)*	$712.15	$415.38	$859.85	$230.77
OPSMA *(Oxnard Pubic Safety Management Association)*	$712.15	$415.38	$859.85	$230.77
SEIU *(Service Employees International Union)*	$712.15	$573.69	$859.85	$230.77
Executives, Attorneys & City Council	$712.15	$573.69	$859.85	$230.77
Confidential/Unrepresented Non-Management	$712.15	$573.69	$859.85	$230.77

Special Note: Premiums have been reduced by the 2024 monthly PEMHCA contribution of $157.00

IMPORTANT

Employees who waive medical coverage must provide proof of other coverage that, at minimum, has the same or better benefits than the PERS Select (PERS Gold) Plan. Employees who do not submit proof of coverage by 10/14/2023 will automatically be enrolled in the PERS Gold PPO Plan, since the State of California requires that all residents maintain qualifying health insurance.

2024 Premiums/Cafeteria (continued)

2024 Premiums for Medical, Dental, and Vision (continued)

Biweekly Dental & Vision Plan Premium Comparison		
	2023 Biweekly Deductions	2024 Biweekly Deductions
Delta Dental/DPO	$52.94	$55.06
CIGNA Dental/DHMO	$15.09	$15.56
EyeMED Vision	$6.86	$7.15
VSP Vision	N/A	$8.55

Dental Cafeteria Dollars	Biweekly Amount
SEIU	$34.25
Other Bargaining Groups *(IAFF, IUOE, OMMA, OPOA, OPSMA, Confidential, Executives/Attorneys/City Council)*	$30.83

Reminder

Open Enrollment Period

Monday September 18, 2023 to Friday October 13, 2023

Open Enrollment Changes Take Effect January 1, 2024

Any questions - please call or email the Benefits Team:

Mike More
Human Resources Manager
Phone: 805-385-7480
Email: mike.more@oxnard.org

Sonia Rosales
Human Resources Technician
Phone: 805-385-7473
Email: sonia.rosales@oxnard.org

CITY OF OXNARD CALIFORNIA

2024 CalPERS – EPO & HMO Basic Plans

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	Anthem Blue Cross EPO Select HMO Traditional HMO	Blue Shield Access+ HMO & Access+ EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance HMO Harmony HMO	Western Health Advantage HMO
Calendar Year Deductible							
• Individual	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maximum Calendar Year Copay or Coinsurance *(excluding pharmacy)*							
• Individual	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)
• Family	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)
Hospital							
• Deductible *(per admission)*	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Surgical Services							
• Outpatient Facility Charge	No Charge	No Charge	No Charge	$15	No Charge	No Charge	No Charge
Emergency Services							
• Emergency Room Copay	$50	$50	$50	$50	$50	$50	$50
• Waived if Admitted	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Physician Services							
• Office Visits *(copay for each service provided)*	$15	$15	$15	$15	$15	$15	$15
• Inpatient Visits	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient Visits	$15	$15	$15	$15	$15	$15	$15
• Urgent Care Services	$15	$15	$15	$15	$15	$15	$15
• Preventive Services	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Surgery/Anesthesia	$15	$15	$15	$15	$15	$15	$15

NOTE: EPO Plans do not apply to the City of Oxnard.

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2024 CalPERS – EPO & HMO Basic Plans (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	Anthem Blue Cross EPO Select HMO Traditional HMO	Blue Shield Access+ HMO & Access+ EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance HMO Harmony HMO	Western Health Advantage HMO
Diagnostic X-Ray/Lab							
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Prescription Drugs							
• Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Prescription Drug Annual Out of Pocket Max – Individual	$7,950 (in addition to Medical OOP limit)	$7,950 (in addition to Medical OOP limit)	$7,950 (in addition to Medical OOP limit)	$7,950 (in addition to Medical OOP limit)	$7,950 (in addition to Medical OOP limit)	$7,950 (in addition to Medical OOP limit)	$7,950 (in addition to Medical OOP limit)
• Prescription Drug Annual Out of Pocket Max – Family	$15,900 (in addition to Medical OOP limit)	$15,900 (in addition to Medical OOP limit)	$15,900 (in addition to Medical OOP limit)	$15,900 (in addition to Medical OOP limit)	$15,900 (in addition to Medical OOP limit)	$15,900 (in addition to Medical OOP limit)	$15,900 (in addition to Medical OOP limit)
• Retail Pharmacy *(30-day supply)*	Tier 1: $5 Tier 2: $20 Tier 3: $50	Generic/Tier 1[1]: $5 Brand Preferred/Tier 2[1]: $20 Non-Preferred/Tier 3[1]: $50 Tier 4[1]: $30	Tier 1: $5 Tier 2: $20 Tier 3: $50	Generic: $5 Brand: $20	Tier 1: $5 Tier 2: $20 Tier 3: $50	Tier 1: $5 Tier 2: $20 Tier 3: $50	Tier 1: $5 Tier 2: $20 Tier 3: $50
• Retail Preferred Pharmacy Maintenance Medications *(90-day supply)*	N/A	Generic/Tier 1[1]: $10 Brand Preferred/Tier 2[1]: $40 Non-Preferred/Tier 3[1]: $100 Tier 4[1]: $60	N/A	N/A	N/A	N/A	N/A
• Mail Order Pharmacy Program *(not to exceed 90-day supply for maintenance drugs)*	Tier 1: $10 Tier 2: $40 Tier 3: $100	Generic/Tier 1[1]: $10 Brand Preferred/Tier 2[1]: $40 Non-Preferred/Tier 3[1]: $100 Tier 4[1]: $60	Tier 1: $10 Tier 2: $40 Tier 3: $100	Generic: $10 Brand: $40 (31-100 day supply	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100
• Mail order maximum copayment per person per calendar year	$1,000	$1,000	$1,000	N/A	$1,000	$1,000	$1,000

1 Tier Formulary is for BSC Trio HMO only. Tier 1 refers to medications classified as 'Generic'; Tier 2 refers to medications classified as "Preferred Brand"; and Tier 3 refers to medications classified as "Non-Preferred Brand".

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2024 CalPERS – EPO & HMO Basic Plans (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	Anthem Blue Cross EPO Select HMO Traditional HMO	Blue Shield Access+ HMO & Access+ EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance HMO Harmony HMO	Western Health Advantage HMO
Durable Medical Equipment							
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Infertility Testing/Treatment							
	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges
Occupational /Physical /Speech Therapy							
• Inpatient *(hospital or skilled nursing facility)*	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient *(office and home visits)*	$15	$15	$15	$15	$15	$15	$15
Diabetes Services							
• Glucose monitors	Coverage varies	No Charge	Coverage varies	No Charge	Coverage varies	Coverage varies	Coverage varies
• Self-management training	$15	$15	$15	$15	$15	$15	$15
Acupuncture							
	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)
Chiropractic							
	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)

NOTE: EPO Plans do not apply to the City of Oxnard.

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2024 CalPERS – PPO Basic Plans

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Calendar Year Deductible						
• Individual	$1,000 [1,3]	$2,500 [3]	$500 [3]	$2,000 [3]	$300	$600
• Family	$2,000 [2,3]	$5,000 [3]	$1,000 [3]	$4,000 [3]	$900	$1,800
Maximum Calendar Year Copay or Coinsurance *(excluding pharmacy)*						
• Individual	$3,000 (coinsurance)	Unlimited	$2,000 (coinsurance)	Unlimited	$2,000	$2,000
• Family	$6,000 (coinsurance)	Unlimited	$4,000 (coinsurance)	Unlimited	$4,000	$4,000
Hospital						
• Deductible *(per admission)*	N/A	N/A	$250	$250	N/A	N/A
• Inpatient	20% [2]	40% [4]	10%	40% [4]	20%	20% [4]
• Outpatient Facility/ Surgery Services	20%	40% [4]	10%	40% [4]	20%	20% [4]
Emergency Services						
• Emergency Room Deductible *(copay waived if admitted as an inpatient or for observation as an outpatient)*	$50 (applies to hospital emergency room facility charge only)		$50 (applies to hospital emergency room facility charge only)		N/A	
• Emergency	20% (applies to other services such as physician, x-ray, lab, etc.)		10% (applies to other services such as physician, x-ray, lab, etc.)		20%	
• Non-Emergency	20%	40%	10%	40%	50%	
	(payment for physician charges only; emergency room facility charge is not covered)		(payment for physician charges only; emergency room facility charge is not covered)		(for non-emergency services provided by hospital emergency room)	

1 **Incentives available to reduce individual deductible (max. $500) or family deductible (max. $1,000) include:** getting a biometric screening ($100 credit); receiving a flu shot ($100 credit); getting a non-smoking certification ($100 credit); getting a virtual second opinion ($100 credit); and getting a condition care certification ($100 credit).

2 Coinsurance waived for deliveries if enrolled in Future Moms Program.

3 Deductible is transferable between PERS Gold and PERS Platinum.

4 Of the allowable amount as defined in the EOC.

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2024 CalPERS – PPO Basic Plans (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Physician Services						
• Office Visits *(copay for each service provided)*	$35 [1]	40% [3]	$20 [2]	40% [3]	$10/$35 [2]	20% [3]
• Inpatient Visits	20%	40% [3]	10%	40% [3]	20%	20% [3]
• Outpatient Visits	$35	40% [3]	$20	40% [3]	20%	20% [3]
• Urgent Care Visits	$35	40% [3]	$35	40% [3]	$35	20% [3]
• Preventive Services	No Charge	40% [3]	No Charge	40% [3]	No Charge	
• Surgery/Anesthesia	20%	40% [3]	10%	40% [3]	20%	20% [3]
Diagnostic X-Ray/Lab						
	20% [4]	40% [3]	10% [4]	40% [3]	20%	20% [3]

1 Reduced to $10 when seen by primary physician
2 $35 for specialist visit
3 Of the allowable amount as defined in the EOC
4 For lab services only – no charge when using Quest Diagnostic or Labcorp.

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2024 CalPERS – PPO Basic Plans (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Prescription Drugs						
• Deductible	N/A		N/A		N/A	
• Prescription Drug Annual Out of Pocket Max – Individual	$2,000		$2,000		$2,000	
• Prescription Drug Annual Out of Pocket Max – Family	$4,000		$4,000		$4,000	
• Retail Pharmacy *(30-day supply)*	Tier 1: $5 Tier 2: $20 Tier 3: $50		Tier 1: $5 Tier 2: $20 Tier 3: $50		Generic: $10 Brand Preferred: $25 Non-Preferred: $45 Compound: $45	
• Retail Preferred Pharmacy Maintenance Medications *(90-day supply)*	N/A		N/A		N/A	
• Mail Order Pharmacy Program *(not to exceed 90-day supply for maintenance drugs)*	Tier 1: $10 Tier 2: $40 Tier 3: $100		Tier 1: $10 Tier 2: $40 Tier 3: $100		Generic: $20 Brand Preferred: $40 Non-Preferred: $75	N/A
• Mail Order Maximum Copayment Per Person Per Calendar Year	$1,000		$1,000		N/A	
Durable Medical Equipment						
	20%	40% [1]	10%	40% [1]	20%	20% [1]
	(pre-certification required for specific equipment)		(pre-certification required for the purchase of equipment priced at $1,000 or more)			
Infertility Testing/Treatment						
	50%		50%		50%	50% [2]

1 Of the allowable amount as defined in the EOC

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2024 CalPERS – PPO Basic Plans (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Occupational / Physical / Speech Therapy						
• Inpatient *(hospital or skilled nursing facility)*	No Charge		No Charge		20% (no copay for inpatient PT/OT by a PAR provider)	20% [2]
• Outpatient *(office and home visits)*	20%	40% (Occupational therapy 20%)	10%	40% (Occupational therapy 10%)	$15 /Office Visit (all other services 20%) [3]	20% [2]
	(pre-certification required for more than 24 visits)		(Pre-certification required for more than 24 visits)			
Diabetes Services						
• Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies	
• Self-management training	$20 [1]	40% [2]	$20 [1]	40% [2]	$20	60% [2]
Acupuncture						
	$15/Visit	40% [2]	$15/Visit	40% [2]	$15 / Office Visit (all other services 20%) [3]	20% [2]
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)			
Chiropractic						
• Office Visit	$15/Visit	40% [2]	$15/Visit	40% [2]	$15 / Office Visit (all other services 20%) [3]	20% 2
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)			

1 $35 for specialist visit

2 Of the allowable amount as defined in the EOC

3 Combined 20 visits per calendar year. (Occupational/Physical/Chiropractor) Combined 20 visits per calendar year

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Dental Plans

When it comes to choosing a dental plan, you want benefits that fit the needs of you and your family. Delta PPO and Cigna Dental HMO both offer comprehensive dental coverage, quality care and excellent customer service. The City allows full-time and permanent part-time employee and their eligible dependents to elect from one of the two plan offerings.

Cigna DHMO

Cigna is our prepaid plan that features set copayments, no annual deductibles and no maximums for covered benefits. Enrollees must select a primary care dentist in the Cigna Dental network from whom they receive treatment as in a traditional dental HMO.

Delta Dental

Delta Dental, our preferred provider organization (PPO) plan, provides access to the largest PPO dentist network in the U.S. Delta Dental dentists agree to accept reduced fees for covered procedures when treating PPO patients. This means your out-of-pocket costs are usually lower when you visit a PPO dentist than when you visit a non-Delta Dental dentist, but you have the freedom to visit any licensed dentist, anywhere in the world.

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Dental Plans (continued)

Cigna Dental DHMO

With the Cigna DHMO Plan, you receive care from your assigned dentist and are informed of copay amounts ahead of time.

Plan Benefits	Cigna
General Plan Information	
• Annual Deductible	
– Individual	$0
– Family	$0
• Waived for Preventive	N/A
• Annual Plan Maximum	N/A
• Lifetime Orthodontia Plan Maximum	Up to Age 19 Children: $980 Adults: $1450
Diagnostic and Preventive Services	
• Diagnostic and Preventive	$0 - $50 copay
• Oral Exams	100% covered limited 4 per year
• Bitewing X-rays	100% covered
• Full Mouth X-rays	100% covered every 36 months
• Cleaning and Scaling	100% covered every six months
• Prophylaxis Treatments	100% covered every six months
• Fluoride Treatments	100% covered
• Space Maintainers	$0 copay
• Sealants	$0 copay
Basic Services	
• Basic	$0 - $225 copay
• Oral Surgery *(Extractions and Other Surgical Procedures)*	$0 - $250 copay
• Endodontic Treatment	$0 - $250 copay
• Periodontic Treatment	$0 - $195 copay
• Re-linings and Re-basings of Existing Removable Dentures	$0 - $50 copay
• Repair or Re-cementing of Crowns, Inlays, Onlays, Dentures or Bridgework	$0 - $150 copay
Major Services	
• Major	$0 - $200 copay
• Crowns, Jackets and Cast Restorations	$0 - $200 copay
• TMJ	$240 per calendar year
• Prosthodontic Benefits *(Fixed Bridges, Partial/Complete Dentures)*	$0 - $200 copay
• Implants	$0 - $600

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Dental Plans (continued)

CIGNA DENTAL VIRTUAL CARE

Helping customers access dental care without leaving home

The dentist will see you now.

Toothaches, chipped teeth and oral infections don't care what time of day it is. But neither do the **Cigna Dental Virtual Care**[1] dentists. If you need dental care and are unable to reach your regular provider, you now have the option to consult with a dentist through a video call. The best part? **Cigna Dental Virtual Care** is available **24 hours a day, seven days a week, 365 days a year!**

Convenient dental consults at home.

While we recommend that you contact your dentist first to see if they can provide virtual care, we recognize that this may not always be possible. That's why we've partnered with The TeleDentists, a virtual dental care company that's been serving customers since 2018. The TeleDentists connects you with a licensed dentist who, through a video call, can help address urgent dental situations like toothaches, infection, swelling, bleeding, and more. They can also prescribe medication[2] to be filled at your local pharmacy, if necessary.

The nature of this type of care delivery precludes dentists from performing more involved procedures, but if the dentist determines such care is needed, they can help guide next steps.

Cost and claim information.

Cigna Dental Virtual Care consults are processed as in-network claims on your plan, and have no co-pay or coinsurance costs. Although Cigna Dental Virtual Care consults do not apply to frequency limits you may have on your plan, they do apply to your plan's annual maximum, if applicable.

How to access Cigna Dental Virtual Care.

If your dentist is unable to assist with your urgent dental care need, simply log on to your **myCigna.com** account and follow the prompts to the virtual care portal.

- You **must** connect to the portal via your **myCigna.com** account in order to use the service without having to enter a payment method.
- Once you've entered the online portal, you will be prompted to create an account on "The TeleDentists" website, and provide basic health information.
- You will be prompted to download and install a video chat application, and then confirm whether you want to see a dentist now, or schedule an appointment for a later time.
- When you are ready to consult with a dentist, you'll enter a virtual waiting room where a dentist will connect with you in ten minutes or less.

Together, all the way.®

Cigna®

Offered by: Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

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Dental Plans (continued)

Frequently asked questions.

My dentist offers virtual visits and is in the CIgna network. Can I use them at no cost if I need urgent care?

Yes! We recommend calling your dentist first as many do provide virtual care.[3]

What if I already have an account with The TeleDentists? Can I use that and still have my costs waived?

In order to have your consult covered by your plan, you must link to The TeleDentists site from your myCigna.com account. This identifies you as a Cigna customer eligible for a consult. Once on the Cigna-branded landing page, you may sign in using your existing account information.

Can my enrolled dependents use this service and are there limitations on the age of patients?

Your enrolled dependents may also use the service. All ages can be evaluated by the dentists on The TeleDentists site, although those under the age of 18 will need to be "accompanied" by a parent or guardian.

Why do I have to create an account on The TeleDentist website? Is it secure?

- In order to provide care, The TeleDentists site needs some information about you, including basic health information, medications you take, allergies you have, etc. This will help the dentist make the most appropriate recommendations during your consult.
- The TeleDentists site meets all federal requirements for protecting personal health information under the Health Insurance Portability and Accountability Act (HIPAA).

Can The TeleDentist dentist prescribe medications if I need them?

Dentists can prescribe medications such as antibiotics and non-narcotic pain relievers. The dentist will send any required prescriptions to the pharmacy of your choice. **There may be pharmacy costs associated with filling the prescription, depending on your medical or prescription plan.[4]**

Do I have to use the video chat function to talk with a dentist? Can they just talk to me on the phone instead?

They are unable to provide consultations by telephone, because the dentist needs to be able to see you and any visual symptoms of the problem you're having. Video chat is the only way a consult can be performed. It's convenient because it allows you to show the dentist things like a broken tooth, inflammation or other problems you're experiencing.

If you have questions, log on to myCigna to chat with a representative or call 1-800-Cigna24. You can also call the number on the back of your ID card.

Cigna

1. Availability of Cigna Dental Virtual Care services may vary by location and plan type and is subject to change.

2. Dentists are unable to prescribe opioid or narcotic medications, and are subject to all laws in your residence state regarding the prescribing of medication.

3. Virtual consultations with Cigna network dentists are subject to applicable frequency limits and annual plan maximums.

4. Prescription medications are not covered on Cigna Dental plans. For information on out-of-pocket costs for prescribed drugs, please refer to your medical or pharmacy plan documents.

All group dental insurance policies and dental benefit plans contain exclusions and limitations. For costs and details of coverage, see your plan documents. The TeleDentists is an independent company and is not affiliated with Cigna. Providers are solely responsible for any treatment provided. Video chat may not be available in all areas. Services are separate from the Cigna dental plan provider networks.

CALL OR CLICK TO FIND A NETWORK DENTIST

It's easy with Cigna Dental Care (DHMO)*

Finding a Cigna Dental Care® network dentist or specialist is quick and easy. And how you do it is up to you. You can search online or call to speak with a customer service representative. **Remember to always pick a network general dentist who's within 25 miles of your location to ensure adequate access.**

Here's how

From myCigna.com – the easiest way

Once you enroll in a Cigna Dental Care plan, register at **myCigna.com**. Then the site will give you information for your specific dental plan. You can search for a dentist using your location, dentist name or procedure. Results can be further narrowed down using the prompts on the results page.

On the go? Not a problem. This information is also on the **myCigna® App**.**

We're with you every step of the way. To help you find better savings, better health and a better experience. From full-service to self-service, Cigna has your dentist search covered.

* The term DHMO ("Dental HMO") is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features. The Cigna Dental Care (DHMO) product availability varies by state and is subject to change.

** The downloading and use of the myCigna Mobile App is subject to the terms and conditions of the App and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

From Cigna.com

- To search for a dentist on **Cigna.com**, visit the site and click **"Find a Doctor, Dentist or Facility."**
- Follow the prompts on screen and when asked to choose your plan, select "CIGNA DENTAL CARE DHMO > Cigna Dental Care Access.
- Review the lists given by specialty. Or narrow your search by typing in provider name, specialty or office name.
- Once you get your search results, you can further refine your search by:
  - Distance
  - Specialty
  - Years in practice
  - Additional languages
- Click on a dentist's name for more details. Such as office hours and location listings with map view.

Call us at 800.Cigna24 (800.244.6224)

Need help finding a Cigna Dental Care network dentist or specialist? Just give us a call. You can use the automated Dental Office Locator. Or, you can speak directly with a customer service representative. You can also ask for a directory customized by dentist type and location.

Call your current dentist

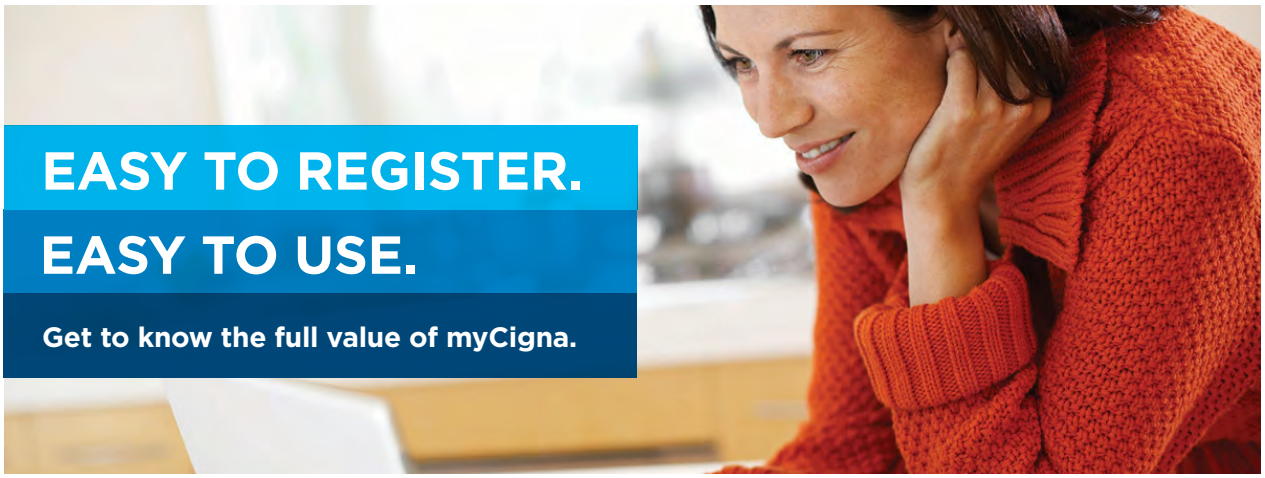
Your current dentist could be in-network. Call the office and ask if they participate in the Cigna Dental Care Access network.

Together, all the way.®

Cigna®

Offered by Cigna Health and Life Insurance Company or its affiliates.

Dental Plans (continued)



There's so much you can do on myCigna.com or the myCigna® App. Access a variety of health and wellness tools.

The myCigna website and app both have an easy, interactive health assessment to help you learn more about your health and what you can do to improve it.

Register today

You can register online or through the app.

1. Go to **myCigna.com** or launch the **myCigna App** and select "Register Now"
2. **Enter** the requested information
3. **Confirm** your identity
4. **Create** your security information and provide your primary email address
5. **Review** and submit

Feel better-protected

Cigna is as committed to helping protect your health information as we are to protecting your health and well-being. That's why we take certain steps to enhance the security of your personal health information on the myCigna website and app.

- **Enhanced registration**
- **Two-step authentication**

Together, all the way.®

Cigna®

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Dental Plans (continued)

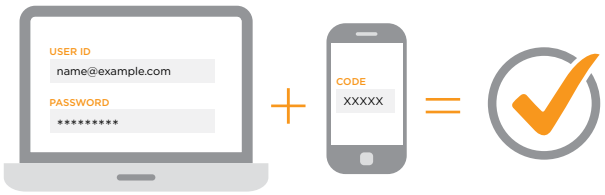
Enhanced registration

When you register for the first time on the myCigna website or app, you'll be required to provide a primary email address. Having an email address helps Cigna better protect the information in your myCigna account. We can send automatic alerts when you update your email or password. Your email address also can be used when you need help recovering your myCigna user ID or password.

Two-step authentication

With two-step authentication, you have an extra layer of security to your myCigna account to further protect your claim, health and account information.

1. First, you'll need **to add, update and verify your contact information**.
2. Once you enable two-step authentication and log in to your myCigna account, you'll be asked **to enter your user ID and password, as well as a six digit code that will be sent to either your email address or mobile phone number**. You'll also be offered to select "Remember this Device." If this choice is selected, you won't be prompted for a code each time you log in to your myCigna account from that device.



Questions?

If you have any questions about the myCigna registration process, call the number on our website under "Contact Us." Customer service representatives are ready to speak with you 24/7/365.

Now compatible with iPhone X devices

The Apple® Face ID® feature for iPhone® X devices is a new way to unlock and authenticate your myCigna App. It's even more convenient than the Touch ID® tool, and makes authenticating fast and easy. Other iPhone users can still use Touch ID to log in to the app.*

Together, all the way.®

Cigna®

Dental Plans (continued)

Delta Dental PPO

Although the percentages of Benefits are the same no matter which dentist you choose, your out-of-pocket expenses may be greater if you choose a Delta Dental PPO Dentist.

Plan Benefits	Delta Dental PPO	
	In-Network	Out-of-Network
General Plan Information		
• Annual Deductible		
– Individual	$0	$0
– Family	$0	$0
• Annual Plan Maximum	$1,500	$1,000
• Lifetime Orthodontia Plan Maximum	$500	$500
Diagnostic and Preventive Services		
• Diagnostic and Preventive	100%	100%
• Oral Exams	100%	100%
• Bitewing X-rays	100%	100%
• Full Mouth X-rays	100%	100%
• Cleaning and Scaling	100%	100%
• Prophylaxis Treatments	100%	100%
• Fluoride Treatments	100%	100%
• Space Maintainers	100%	100%
• Sealants	100%	100%
Basic Services		
• Basic	100%	100%
• Oral Surgery *(Extractions and Other Surgical Procedures)*	100%	100%
• Endodontic Treatment	100%	100%
• Periodontic Treatment	100%	100%
• Re-linings and Re-basings of Existing Removable Dentures	50%	50%
• Repair or Re-cementing of Crowns, Inlays, Onlays, or Bridgework	70 - 100%	70 - 100%
Major Services		
• Major	100%	100%
• Crowns, Jackets and Cast Restorations	100%	100%
• Prosthodontic Benefits *(Fixed Bridges, Partial/Complete Dentures)*	50%	50%
• Implants	50%	50%

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Dental Plans (continued)

DELTA DENTAL

Resources at your fingertips

Go online to manage your plan

Whether you need to check your benefits or select a new dentist, you can do it all with Delta Dental's online tools.

Create an account

What you can do:

- Check your plan details and eligibility.
- Browse claim history.
- Download plan documents.
- Find an in-network dentist.
- View your member ID card or print a paper copy.
- Update your settings to paperless.

Try it out: Go to **deltadentalins.com** and choose **Log in** to create an account or log in to your existing account.

Tip: Access your benefits info on mobile, tablet or desktop!

Find an in-network dentist

What you can do:

- Search by distance, specialty, language spoken, extended office hours, wheelchair accessibility and more.
- Browse Yelp ratings and reviews from real patients, and check out DentaQual scores for an objective quality metric based on actual claims data.

Try it out: Go to **deltadentalins.com**, enter your address or ZIP code and select your network. Not sure which network to choose? Log in to your account first and follow the prompts to find a dentist.

deltadentalins.com/enrollees

Dental Plans (continued)

Understand your plan

What you can do:

- Browse answers to frequently asked questions.
- Get tips on planning for a dental visit.
- Find claim forms.
- Learn how to go paperless, sign up for a virtual dental visit and coordinate coverage with two or more plans.

Try it out: Visit **deltadentalins.com/enrollees** for useful resources and tips.

Explore dental wellness

What you can do:

- Browse articles on everything from acid reflux to xylitol.
- Find delicious recipes for healthy meals.
- Check out videos on preventive care and common procedures.

Try it out: Visit **deltadentalins.com/wellness** to start learning.

Download the app

What you can do:

- Check your plan details and eligibility.
- Browse claim history.
- View your member ID card.
- Get a cost estimate.
- Find an in-network dentist.

Try it out: Search for Delta Dental in the App Store or Google Play.

Tip: Don't need another app? Just visit **deltadentalins.com** on your smartphone or tablet and log in to your account.

Our Delta Dental enterprise includes these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT.

Dental Plans (continued)

DELTA DENTAL

Savings to smile about

Support a healthy lifestyle with LifePerks

Wellness is more than oral health

That's why, as a Delta Dental member, you have access to a wide variety of local and national offers and discounts to help you care for your whole body and maintain a healthy life.

How do I get the discounts?

Register and learn more about LifePerks today. After registering for LifePerks, visit the online platform or take advantage of the members-only deals periodically emailed to you.

Special offers	
Oral health	Discounts to help keep your oral health on track
Health & wellness	Access whole body health deals on nutrition, fitness equipment and gym memberships
Lifestyle	Save big on childcare, groceries, home services, pet insurance and financial and auto services
Travel & entertainment	Keep the whole family entertained with discounted access to movie theaters, theme parks, vacation planning and travel services
Customer service	24/7 email **customer support**

Register and learn more about LifePerks today.

Our Delta Dental enterprise includes these companies in these states: Delta Dental of California — CA, Delta Dental of the District of Columbia — DC, Delta Dental of Pennsylvania — PA & MD, Delta Dental of West Virginia, Inc. — WV, Delta Dental of Delaware, Inc. — DE, Delta Dental of New York, Inc. — NY, Delta Dental Insurance Company — AL, DC, FL, GA, LA, MS, MT, NV, TX and UT.

LifePerksML.lifemart.com

EF100 #25252 (rev. 6/23)

Vision Plan

The City has partnered with The Standard to offer two vision plans; Plan I will be through the EyeMed network, and Plan II will be through the VSP network. The plans pay benefits and offers discounts for most vision care expenses you incur while covered by the plan, subject to the maximum amounts shown below. Vision coverage is available for full-time and permanent part-time employees and their eligible dependents. If you use providers with in your assigned network based on your plan of choice, your costs for most services and materials are limited to the applicable copays.

	EyeMed Plan		VSP Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Benefits Frequency				
• Eye Exam	Every 12 months			
• Contacts or Lenses	Every 12 months			
• Frames	Every 12 months		Every 12 months	
Examinations				
• Exam with Dilation as Necessary	$10 copay	Reimbursed up to $35	$10 copay	Reimbursed up to $45
Standard Plastic Lenses				
• Single Vision	Covered in full	Reimbursed up to $25	Covered in full	Reimbursed up to $30
• Bifocal Lens	Covered in full	Reimbursed up to $40	Covered in full	Reimbursed up to $50
• Trifocal Lens	Covered in full	Reimbursed up to $55	Covered in full	Reimbursed up to $65
• Lenticular	20% discount	Not Covered	Covered in full	Reimbursed up to $100
• Standard Progressive	$65 + Lens Copay	Not Covered	Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Bifocal allowance.
• Premium Progressive *(Tiered)*	- 20% discount - $120 allowance + Standard progressive cost	Not covered	Up to provider's contracted fee for lined Bifocal lenses.	Up to lined Bifocal allowance
Contact Lenses				
• Medically Necessary	Covered in Full	Reimbursed up to $200	Covered in full	Reimbursed up to $210
• Elective	Up to $180	Up to $144	Up to $180	Reimbursed up to $145
• Standard Fit Exam	Up to $55	Not covered	Up to $60 cost	Not covered
Frames	$180 Allowance	Reimbursed up to $90	$180*	Reimbursed up to $70

* The Costco and Walmart allowance will be the wholesale equivalent

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Life and AD&D – Class 1 & 2

The Standard Life Insurance

The City currently pays 100% of your monthly insurance premium. Basic Life Insurance would help your family or beneficiary cover costs in your absence. AD&D insurance provides additional protection for your beneficiaries in the event of your accidental death or loss of a limb or eye sight.

Life insurance coverage will cease after termination of employment but conversion is an option.

Benefits at a Glance

	Class 1	Class 2
	OMMA, OPSMA, Unrepresented Executive, Attorneys, Council Members	All Regular Full-Time Employees Except Temporary or Seasonal Workers
Eligible Member	All employees or active participants working more than 30 or more hours per week	
Benefit Amount	1x Annual salary up to $500,000	$5,000
Guarantee Issue	$300,000	$5,000
Accelerated Death Benefit	80% of benefit not to exceed $250,000	80% of benefit not to exceed $4,000
Waiver of Premium	If you become totally disabled while active and insured before your 60th birthday, premium is waived. Proof of disability is required.	
Conversion	If you leave your job for any reason you may be able to change your group life coverage to an individual policy. You must apply for coverage by completing the request for Group Life Conversion form. For questions, please call 800.378.4668.	
Age reduction and exclusions	At age 70, amounts reduce to 50%	

Additional Supplemental Life Insurance is available at the employee's cost. Please inquire within Human Resources/Benefits for further details.

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Voluntary Life and AD&D (Employee Paid)

The Standard

Benefits at a Glance

Eligible Member: All eligible employees working 30 or more hours per week.

Optional group term life insurance benefit amount:

- Life insurance in increments of $10,000 to a maximum of $500,000. If you wish to purchase an amount over the guarantee issue amount of $300,000, evidence of insurability will be required.

Optional employee AD&D benefit amount:

- Same as Voluntary Life amount. Optional AD&D coverage is included for all employees who elect Optional Voluntary Coverage.
- Optional Accidental Death and Dismemberment Insurance pays a benefit to your beneficiary if your death is caused by an accident. You may also get part of this benefit if an accident results in the loss of sight, a limb, certain fingers or toes, speech, hearing or certain types of paralysis (not able to move part of your body).

Optional life coverage for your family:

- You may also choose additional life coverage for your spouse and your children.
- You may purchase coverage for your spouse in increments of $5,000 up to $250,000.
- You may purchase coverage for your children (from birth - age 26 years) in increments of $1,000 up to $10,000.
- Any election will require Evidence of Insurability form to be completed and approved by The Standard.
- Dependents coverage may not exceed 100% of the employee's benefit amount.

Waiver of Premium: If you become totally disabled while active and insured before your 60th birthday, premium is waived.

Portability: If you leave employment for reasons other than retirement or disability, this feature allows you to take your optional life.

Age Reduction and Exclusions:

- At age 70 amount reduces to 50%
- Spouse coverage reduced by 50% at age 70

Guaranteed Issue:

- **For You:** $300,000 (for new hires enrolled within 31 days of becoming eligible)
- **For Your Spouse:** Up to $50,000

Disability

OMMA, OPSMA, Unrepresented Executive, Attorneys, Council Members

Short Term Disability (STD)

This benefit allows you to continue receiving a percentage of your salary in the event you become ill or injured and cannot perform your regularly assigned duties. This benefit is paid for by the City of Oxnard.

You must be working a minimum of 30 hours a week.

- **Waiting Period:** 30 days
- **Benefit Period:** 9 weeks
- **Benefit Percentage:** 66 2/3 with a maximum of $3,000 per week

Long Term Disability (LTD)

The City of Oxnard offers an LTD benefit through The Standard. Employees are able to receive the lesser of 66 2/3% of your basic monthly earnings, up to a maximum of $15,000 per month.

You must be working a minimum of 30 hours a week.

- **Waiting Period:** 90 days
- **Benefit Period:** SSNRA*
- **Benefit Percentage:** 66 2/3 with a maximum of $15,000 per month

* SSNRA stands for Social Security Normal Retirement Age. This means your normal retirement age under the Federal Social Security Act, as amended.

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Life Insurance

The Life Services Toolkit

Resources and Tools to Support You and Your Beneficiary

Group Life insurance through your employer gives you assurance that your family will receive some financial assistance in the event of a death. But coverage under a group Life policy from Standard Insurance Company (The Standard) does more than help protect your family from financial hardship after a loss. We have partnered with Morneau Shepell to offer a lineup of additional services that can make a difference now and in the future.

Online tools and services can help you create a will, make advance funeral plans and put your finances in order. After a loss, your beneficiary can consult experts by phone or in person, and obtain other helpful information online.

The Life Services Toolkit is automatically available to those insured under a group Life insurance policy from The Standard.

Services to Help You Now

Visit the Life Services Toolkit website at **standard.com/mytoolkit** and enter user name "assurance" for information and tools to help you make important life decisions.

- **Estate Planning Assistance:** Online tools walk you through the steps to prepare a will and create other documents, such as living wills, powers of attorney and health care agent forms.
- **Financial Planning:** Consult online services to help you manage debt, calculate mortgage and loan payments, and take care of other financial matters with confidence.
- **Health and Wellness:** Timely articles about nutrition, stress management and wellness help employees and their families lead healthy lives.
- **Identity Theft Prevention:** Check the website for ways to thwart identity thieves and resolve issues if identity theft occurs.
- **Funeral Arrangements:** Use the website to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements in advance.

If you are a recipient of an Accelerated Benefit,[1] you may access the services for beneficiaries outlined on the next page.

continued on the next page

1 An Accelerated Benefit allows a covered individual who becomes terminally ill to receive a portion of the Life insurance proceeds while living, if all other eligibility requirements are met.

Standard Insurance Company
1100 SW Sixth Avenue
Portland, OR 97204

standard.com

Life Services Toolkit
SI **17526** (10/17) EE

The Life Services Toolkit - The Standard (continued)

Services for Your Beneficiary

Life insurance beneficiaries[2] can access services for 12 months after the date of death. Recipients of an Accelerated Benefit can access services for 12 months after the date of payment.

These supportive services can help your beneficiary cope after a loss:

- **Grief Support:** Clinicians with master's degrees are on call to provide confidential grief sessions by phone or in person. Your beneficiaries are eligible for up to six face-to-face sessions and unlimited phone contact.

  Our clinicians may offer your beneficiaries additional grief support through books sent to their home, based on each individual's needs. As part of this program, age-appropriate books can be sent for children and teens.

- **Legal Services:** Your beneficiaries can obtain legal assistance from experienced attorneys. They can:

  - Schedule an initial 30-minute office and a telephone consultation with a network attorney. Beneficiaries who wish to retain a participating attorney after the initial consultation receive a 25 percent rate reduction from the attorney's normal hourly or fixed-fee rates.

  - Obtain an estate-planning package that consists of a simple will, a living will, a health care agent form and a durable power of attorney.

- **Financial Assistance:** Your beneficiaries have unlimited phone access to financial counselors who can help with issues such as budgeting strategies, and credit and debt management, including hour-long sessions on topics requiring more in-depth discussion.

- **Support Services:** During an emotional time, your beneficiaries can receive help planning a funeral or memorial service. Work-life advisors can guide them to resources to help manage household repairs and chores; find child care and elder care providers; or organize a move or relocation.

- **Online Resources:** Your beneficiaries can easily access additional services and features on the Life Services Toolkit website for beneficiaries, including online resources to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements.

Beneficiaries can participate in phone consultations or in-person meetings with trained grief counselors.

For beneficiary services, visit standard.com/mytoolkit (user name = support) or call the assistance line at 800.378.5742.

2 The Life Services Toolkit is not available to Life insurance beneficiaries who are minors or to non-individual entities such as trusts, estates, charities.

The Life Services Toolkit is provided through an arrangement with Morneau Shepell and is not affiliated with The Standard. Morneau Shepell is solely responsible for providing and administering the included service. This service is not an insurance product.

Seguro de Vida

Instrumentos de servicios para la vida

Recursos y herramientas para apoyarle a usted y a su beneficiario

El Seguro de Vida Colectivo a través de su empleador le da la tranquilidad de que su familia recibirá alguna ayuda financiera en caso de fallecimiento. Pero la cobertura bajo una póliza de Seguro de Vida Colectivo de Standard Insurance Company (The Standard) hace más que poder ayudar a su familia ante una dificultad financiera por una pérdida. Nos hemos asociado a Morneau Shepell para ofrecerle una oferta de servicios extra que hacen una diferencia ahora y en el futuro.

Las herramientas y servicios en línea le pueden ayudar a crear un testamento, hacer planificaciones con antelación para funerales y poner sus finanzas en orden. Después de una pérdida, los beneficiarios pueden consultar a expertos por teléfono o en persona, y obtener otra información útil en línea.

Los Instrumentos de servicios para la vida están disponibles automáticamente para aquellas personas aseguradas bajo una póliza de Seguro de Vida Colectivo de The Standard.

Servicios que le ayudan ahora

Visite el sitio web de los Instrumentos de servicios para la vida en **www.standard.com/mytoolkit** e introduzca el nombre de usuario "assurance" para obtener información y herramientas que le ayuden a tomar decisiones importantes sobre su vida.

- **Ayuda con la planificación de la herencia:** Las herramientas en línea le acompañan a través de los pasos para preparar un testamento y crear otros documentos, como documentos de voluntades anticipadas, poderes notariales, formularios de agentes de atención médica y fideicomisos en vida.
- **Planificación financiera:** Consulte los servicios en línea para que le ayuden a gestionar su deuda, calcular su hipoteca y los pagos de su préstamo, y ocuparse de otros asuntos financieros con confianza.
- **Salud y bienestar:** Artículos oportunos sobre nutrición, manejo del estrés y bienestar que ayudan a los empleados y a sus familias a vivir de manera saludable.
- **Prevención de usurpación de la identidad:** Chequee el sitio web para conocer maneras de frustrar las acciones de los ladrones de identidades, y resolver problemas si ocurriera una usurpación de identidad.
- **Arreglos para el funeral:** Use el sitio web para calcular los costos del funeral, encontrar servicios relacionados con el funeral y tomar decisiones sobre los arreglos del funeral con antelación.

Si es el receptor de un Beneficio adelantado,[1] usted podría acceder a los servicios para beneficiarios descritos en la página siguiente.

Continúa en el reverso

1 Un Beneficio adelantado permite a una persona cubierta que enferme terminalmente a recibir una parte de las cuantías del Seguro de Vida mientras siga con vida, si se cumplen el resto de requisitos de derecho de participación.

Standard Insurance Company
1100 SW Sixth Avenue
Portland, OR 97204

standard.com

Instrumentos de servicios para la vida
SI **17526-SPU** (10/17) EE

The Life Services Toolkit - The Standard (continued)

Servicios para su beneficiario

Los beneficiarios del Seguro de Vida[2] pueden acceder a los Servicios durante 12 meses después de la fecha del fallecimiento. Los receptores de un Beneficio adelantado pueden acceder a los servicios durante 12 meses después de la fecha de pago.

Estos servicios de apoyo pueden ayudar a que su beneficiario supere una pérdida:

- **Apoyo al dolor:** Médicos con maestrías están disponibles para proporcionar sesiones confidenciales para superar el dolor por teléfono o en persona. Los beneficiarios tienen derecho a recibir hasta seis sesiones en persona y comunicaciones telefónicas ilimitadas.

  Nuestros médicos pueden ofrecer a sus beneficiarios apoyo extra para superar el dolor a través de libros enviados a su hogar, en base a las necesidades de cada persona. Como parte de este programa, podemos enviar libros clasificados por edad para niños y adolescentes.

- **Servicios jurídicos:** Sus beneficiarios pueden obtener asistencia jurídica de abogados con experiencia. Por ejemplo, pueden:
  - Pueden programar una consulta en la oficina de 30 minutos o por teléfono con un abogado de la red. Los beneficiarios que deseen contratar los servicios de un abogado participante, recibirán una reducción de 25 por ciento en la tarifas normales por hora o fijas del abogado.
  - Pueden obtener un paquete de planificación de herencia que consta de un testamento simple, un documento de voluntades anticipadas, un formulario de agente de atención médica y un poder notarial.
- **Asistencia financiera:** Los beneficiarios disponen de acceso telefónico ilimitado a consejeros financieros que pueden ayudar con asuntos como estrategias presupuestarias, y gestión del crédito y la deuda, incluyendo sesiones de una hora sobre temas que requieran un tratamiento más en profundidad.
- **Servicios de apoyo:** Durante unos momentos tan sensibles, los beneficiarios pueden recibir ayuda para planificar un funeral o un servicio conmemorativo. Los asesores de Work-life pueden guiarles para obtener recursos que les ayuden a gestionar reparaciones domésticas y tareas rutinarias; encontrar proveedores de atención infantil y para personas mayores; u organizar una mudanza reubicación.
- **Recursos en línea:** Los beneficiarios pueden acceder fácilmente a servicios y características extra en el sitio web de los Instrumentos de servicios para la vida, incluyendo recursos en línea para calcular los costos del funeral, encontrar servicios relacionados con el funeral y tomar decisiones sobre los arreglos del funeral.

Los beneficiarios pueden participar en consultas telefónicas o reuniones en persona con consejeros capacitados para ayudarle a superar el dolor.

Para obtener servicios para beneficiarios, visite standard.com/mytoolkit (Nombre de usuario = support) o llame a la línea de asistencia telefónica al 800.378.5742.

2 Los Instrumentos de servicios para la vida no están disponibles para los beneficiarios del Seguro de Vida que sean menores de edad o para entidades no individuales como fideicomisos, administradores de herencias u organizaciones caritativas.

Los Instrumentos de servicios para la vida se proporcionan a través de un acuerdo con Morneau Shepell, el cual no está afiliado con The Standard. Morneau Shepell es el único responsable de proporcionar y administrar el servicio incluido. El servicio del EAP no es un seguro.

Employee Assistance Program (EAP)

A helping hand when you need it.

Rely on the support, guidance and resources of your Employee Assistance Program.

There are times in life when you might need a little help coping or figuring out what to do. Take advantage of the Employee Assistance Program,[1] which includes WorkLife Services and is available to you and your family in connection with your group insurance from Standard Insurance Company (The Standard). It's confidential — information will be released only with your permission or as required by law.

Connection to Resources, Support and Guidance

You, your dependents (including children to age 26)[2] and all household members can contact the program's master's-level counselors 24/7. Reach out through the mobile EAP app or by phone, online, live chat, and email. You can get referrals to support groups, a network counselor, community resources or your health plan. If necessary, you'll be connected to emergency services.

Your program includes up to six counseling sessions per issue. Sessions can be done in person, on the phone, by video or text.

EAP services can help with:

- Depression, grief, loss and emotional well-being
- Family, marital and other relationship issues
- Life improvement and goal-setting
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Financial and legal concerns
- Identity theft and fraud resolution
- Online will preparation and other legal documents

Contact **EAP**

877.851.1631
(TTY Services: 711)
24 hours a day,
seven days a week

healthadvocate.com/standard6

NOTE: It's a violation of your company's contract to share this information with individuals who are not eligible for this service.

With EAP, personal assistance is immediate, confidential and available when you need it.

WorkLife Services

WorkLife Services are included with the Employee Assistance Program. Get help with referrals for important needs like education, adoption, daily living and care for your pet, child or elderly loved one.

Online Resources

Visit **healthadvocate.com/standard6** to explore a wealth of information online, including videos, guides, articles, webinars, resources, self-assessments and calculators.

1 The EAP service is provided through an arrangement with Health Advocate℠, which is not affiliated with The Standard. Health Advocate℠ is solely responsible for providing and administering the included service. EAP is not an insurance product and is provided to groups of 10–2,499 lives. This service is only available while insured under The Standard's group policy.

2 Individual EAP counseling sessions are available to eligible participants 16 years and older; family sessions are available for eligible members 12 years and older, and their parent or guardian. Children under the age of 12 will not receive individual counseling sessions.

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

SI **17200**

Employee Assistance Program-6 EE
(8/21)

Employee Assistance Program (EAP) (continued)

Select a topic: **What Is EAP?** **Using EAP** **Counseling Services** **Legal and Financial Services** **WorkLife Services**

TheStandard®

PROGRAM DESCRIPTION

Employee Assistance Program

Employee Assistance Program (EAP) (continued)

At some point, we all need help coping or making difficult decisions. The Employee Assistance Program makes it easy to access support, guidance and resources.[1] EAP is there for you and your family through your Group Long Term Disability insurance from Standard Insurance Company (The Standard). And it's confidential — information will be released only with your permission or as required by law.

Health Advocate℠ provides our EAP services.[2] Their professionals can help with referrals to support groups, a network counselor, community resources or your health plan. If necessary, their professionals can connect you to emergency services.

Coordinating with your health plan(s)

An EAP counselor will make every effort to coordinate with in-network providers if you need more than the included EAP sessions. They'll also share available resources and referral options.

EAP services can help with:

- Depression, grief, loss and emotional well-being
- Family, marital and other relationship issues
- Life improvement and goal-setting
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Financial and legal concerns
- Identity theft resolution
- Online will preparation and other legal documents

1 The EAP service is provided through an arrangement with Health Advocate, which is not affiliated with The Standard, to groups of 10 – 2,499 covered employees. This service is only available while insured under The Standard's Long Term Disability (LTD) policy. The Standard may change providers or terminate service at any time. Health Advocate is solely responsible for providing and administering the service.

2 Health Advocate, Inc. is a national health advocacy, patient advocacy and assistance company. Their expertise in EAP and work/life services stretches back nearly 40 years to 1979. Their highest priority is treating members with respect and dignity, protecting their privacy and working to eliminate the stigma often associated with using mental health services. Health Advocate's services cover more than 55,000 clients and 32 million lives. Their services also help support managers, supervisors and HR professionals. Health Advocate is headquartered in Plymouth Meeting, PA, with more locations in the western, central, and eastern parts of the U.S.

Employee Assistance Program (EAP) (continued)

Getting Help Is Easy

Connect with EAP support by phone, email, online and live chat. There's even a mobile app.

Contact EAP 24 Hours a Day, Seven Days a Week

877.851.1631 (phone)
For TTY services dial 711
answers@healthadvocate.com

healthadvocate.com/standard6

Online Resources

Visit healthadvocate.com/standard6 to explore articles, webinars, financial calculators, health assessments and web links to many government and nonprofit services.

Get the EAP Mobile App

1. Visit Google Play or the App Store.
2. Find the EAP Mobile App.
3. Choose *The Standard — EAP — 6 Visits.*

Download on the App Store | GET IT ON Google Play

Who Is Eligible to Use EAP Services?

- You
- Your spouse
- Domestic partner
- Married or unmarried dependent children to age 26[1]
- All other household members

EAP services are available for up to 30 days after your coverage and/or employment ends. If you pass away, your dependents can use the services for up to 90 days.

1 Individual EAP counseling sessions are available to eligible participants 16 years and older; family sessions are available for eligible members 12 years and older, and their parent or guardian. Children under the age of 12 will not receive individual counseling sessions.

Employee Assistance Program (EAP) (continued)

When you contact EAP, you'll have the support of a master's level counselor who can do an immediate assessment, consult and refer you for help.

Counseling Sessions

Your program offers up to **six counseling sessions** for each issue that each eligible person wants to address. Sessions can be in person, on the phone, through video or by text.

Counseling sessions can be:

- In person
- On the phone
- Through video
- By text

How Referrals Work

- Life-threatening emergencies have appropriate care coordinated upon initial contact.
- Urgent appointments are offered and available within 24 hours.
- Routine appointments are offered and available within five business days.

A Network of Qualified Providers

- National network of more than 62,000 providers
- Network in place for over 30 years
- Open-panel policy (no closed networks)

Standards for Clinical Providers

- Minimum of a master's degree
- State licensure

Consistent Support

A master's level counselor coordinates your telephone intake, case management and follow up to ensure continuity of care.

Employee Assistance Program (EAP) (continued)

Legal Services

EAP can connect you with resources to help with legal issues.

- Nationwide panel of attorneys
- Up to 30-minute free face-to-face or telephone consultation for each separate legal matter
- 25% discount if you retain an in-network attorney
- Coverage for most legal issues, including civil, personal/family, credit, elder law, tax law, real estate and estate planning
- Online will preparation and other legal documents

Financial Services

EAP provides support to help with financial concerns.

- Up to 30-minute free financial counseling session for each issue from Certified Consumer Credit Counselors, Certified Credit Report Reviewers and financial planners
- Identity theft consultations and free identity theft kit if your identity has been stolen

Money Management

- Spending habits
- Budgeting strategies
- Managing credit
- Managing debt
- Debt consolidation
- Financial planning information
- Goal setting
- Credit report and credit score issues
- Homeownership and other personal finance issues

Employee Assistance Program (EAP) (continued)

WorkLife Services

EAP comes with WorkLife Services. WorkLife Specialists can provide resources and referrals for important needs like parenting, special needs children, caregiver management, education, adoption, daily living and care for your pet, child or elderly loved one.

Online Savings and Discount Center

The savings center is available on the EAP website. Get up to 50% discounts on name-brand, practical and luxury items. Save on travel, restaurants, flowers, home, apparel and more.

Wellness discounts are available online through the Health tab on the website, including discounts on NutriSystem, Weight Watchers, Vitamin Shoppe, fitness and personal care.

WorkLife Services provides expert, multilingual telephonic and internet-based consultation and referral for:

- Child care services
- Elder care services
- Health and wellness
- Emotional and well-being
- Daily living resources, relocation and community volunteering

EAP support is immediate, personal, confidential and available when you need it.

Contact EAP

877.851.1631 (phone)

For TTY services dial 711

answers@healthadvocate.com

healthadvocate.com/standard6

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

SI **22193**

Employee Assistance Program-6
(8/21) EE

Travel Assistance - The Standard

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

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

Security That Travels with You

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

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

Contact Travel Assistance

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

Everywhere else
+1.609.986.1234

Text:
+1.609.334.0807

Email:
medservices@assistamerica.com

Get the App

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

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

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

Reference Number:
01-AA-STD-5201

Download on the App Store | GET IT ON Google Play

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

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

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

3 Must be arranged by Assist America, Inc.

SI **14684**

Travel Assistance EE
(6/20)

Travel Assistance - The Standard (continued)

American Fidelity Flexible Spending Benefits (Section 125)

Health Flexible Spending Account (FSA)

A Health Flexible Spending Account (FSA) allows you to allocate money on a pre-tax basis for qualified medical expenses for you and your family. Qualified expenses include anything from copays, medical deductibles, prescriptions and much more.

The minimum amount you may contribute to a Health Flexible Spending Account for the plan year is $150; the maximum is $3,050 and up to $5,000 for dependent care.

Partial List of Eligible Expenses (for a complete list of eligible expenses, please visit www.americanfidelity.com)

- Copays/coinsurance
- Deductibles
- Dental treatments
- Diabetic supplies
- Prescription drugs and medicines
- Eye exams, eyeglasses, contact lenses, contact lens solution and enzyme
- Flu shots
- Immunizations
- Lab fees
- Laser/LASIK/RK surgery
- Medical exams
- Orthodontia
- Psychiatric care
- Wheelchair
- X-rays

Your Section 125 Plan

Participating in your employer's Section 125 Plan helps reduce your tax and increase your spendable income. Many qualified benefit premiums you pay under the plan are paid on a pre-tax basis.

Benefits Available to You

Healthcare Flexible Spending Account (HCFSA): Health Flexible Spending Account (FSA) allows you to allocate money on a pre-tax basis to be used for qualified medical expenses for you and your family.

Dependent Care Account (DCA): Dependent flexible spending account allows you to set aside pre-tax dollars to reimburse yourself for eligible dependent care expenses.

Cancer Insurance*,+: If you were unexpectedly faced with a cancer diagnosis, will your major medical insurance be enough? Limited Benefit Cancer Insurance may help. Benefit payments are made directly to you, allowing you to pay for expenses like copayments, hospital stays, and house and car payments.

Accident Only Insurance*,+: Accidents are inevitable. Even though you can't always prepare for unforeseen events, you can plan ahead. A Limited Benefit Accident Only Insurance plan may help ease the impact on your finances. This plan pays benefits directly to you, helping you cover any unplanned medical expenses due to a covered accident.

Life Insurance*,:** Ensuring your family is financially protected in the event of a loss is an important way of caring for their needs. Life Insurance can help. Securing a life insurance policy helps provide peace of mind knowing it will help take care of your family after you're gone.

Group Critical Illness Insurance*,+,#: If you experience an event such as a heart attack or stroke, Limited Benefit Critical Illness Insurance may help. It pays a lump sum amount to help with expenses that may not be covered by major medical insurance - house payments, everyday expenses, lost income, and more.

Post-tax Benefits

Disability Income Insurance*: In the simplest of terms, this plan helps protect your income. Disability Income Insurance is designed to help protect you if you can't work due to a covered injury or sickness. It provides steady benefits to cover expenses, paying a percentage of your gross monthly earnings.

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* These products may contain limitations, exclusions, and waiting periods.

\+ This product may be inappropriate for people who are eligible for Medicaid coverage.

** Not generally qualified benefits under Section 125 Plans.

\# Group Critical Illness is only offered on an after tax-basis.

These are brief descriptions of the actual policies. All products may not be available in all states.

HRA, FSA, HSA numbers are reflected for the 2023 calendar year. 2024 amounts are not typically determined until after the release of the Benefit Guide. Employees making elections for the 2024 year should keep this in mind.

American Fidelity Assurance Company

City of Oxnard

Plan Year
1/1/2023 - 12/31/2023

AMERICAN FIDELITY
a different opinion

EMPLOYER BENEFIT SOLUTIONS FOR THE PUBLIC SECTOR

Plan for tomorrow, today.

Everyone knows health insurance doesn't pay for everything. Do you feel fully protected? Reviewing and updating your coverage each year is important.

Get help with your options. Stop by and see an American Fidelity account manager.

Healthcare Flexible Spending Accounts

- let you take money from your paycheck, pre-tax
- allow you to put money into an account to pay for eligible medical costs

americanfidelity.com/info/fsa

Long-Term Disability Income Insurance

AF™ **Long-Term Disability Income Insurance**

- helps provide a steady benefit while you are unable to work due to a covered disability
- helps protect your income in case of a covered injury or illness

americanfidelity.com/info/disability

Short-Term Disability Income Insurance

AF™ **Short-Term Disability Income Insurance**

- provides part of your monthly income during your qualifying disability coverage period
- allows you to use -benefit dollars to pay for living expenses

americanfidelity.com/info/disability

Accident Only Insurance

AF™ **Limited Benefit Accident Only Insurance**

- may help manage out-of-pocket costs to treat injuries resulting from a covered accident
- provides benefit payments directly to you

americanfidelity.com/info/accident

An unintentional injury averages **$4,339** in medical expenses.

National Safety Council, Injury Facts, 2019 Web.

CLICK HERE to watch a video on Flexible Spending Accounts (FSA)

American Fidelity Assurance Company (continued)

Cancer Insurance

AF™ **Limited Benefit Individual Cancer Insurance**

- may help ease the financial burden of cancer treatment, so you can focus on recovery
- provides benefit payments directly to you

americanfidelity.com/info/cancer

Critical Illness Insurance

AF™ **Limited Benefit Critical Illness Insurance**

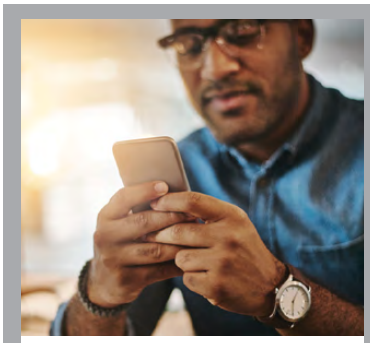
- pays a benefit upon diagnosis of certain covered life-altering illnesses
- helps with costs not covered by medical insurance

americanfidelity.com/info/critical-illness

Life Insurance

AF™ **Life Insurance** may help ensure your family is financially protected in the event of a loss. You own the policy, so you can take it with you to a different job or into retirement.

americanfidelity.com/info/life



Manage Medical Costs

Many people need help with the cost of what health insurance doesn't cover.

Learn about insurance and reimbursement accounts that may be available to you.

americanfidelity.com/info

24/7 Access with AFmobile®

Manage your insurance benefits and reimbursement accounts all from the palm of your hand.

View account balances

Manage claims and reimbursements

Submit documentation

Receive alerts

Maintain personal information

Get Started

Register at americanfidelity.com/register or **download AFmobile** and select the New User link.

Please allow one business day after you enroll before registering for an online account. If you already have an account, your username and password will be the same for AFmobile.

Flexible Spending Accounts

Everyone likes saving money.

Flexible spending accounts (FSA) allow you to save part of your paycheck, before taxes, to pay for eligible costs throughout the year.

Types of Accounts

- Healthcare FSAs
- Limited Purpose FSAs
- Dependent Care Accounts

Explore your savings options at **americanfidelity.com/info/fsa**

To calculate medical costs that may not be covered by insurance, visit americanfidelity.com/fsa-worksheet

Examples of Eligible Expenses

- Asthma treatments
- Chiropractic care
- Contact lenses
- Copays
- Dental services
- Eye exam/eyeglasses
- Fertility treatments
- Laser eye surgery
- Over-the-counter bandages
- Physical exams
- Physical therapy
- Prescriptions
- Prenatal care
- Sunscreen with 15 SPF or higher
- Walkers/wheelchairs

americanfidelity.com/eligible-expenses

American Fidelity Assurance Company (continued)

City of Oxnard

File Your Claims Faster

AFmobile®

Our mobile app is the easiest way to submit your claims and documentation. Upload documentation* directly from your device's picture gallery.

americanfidelity.com®

Filing online is convenient, secure, and provides faster claim processing than filing by paper. From your laptop or desktop, log in to file a claim and upload documentation*.

Need assistance?

Visit americanfidelity.com/fileaclaim

**The Internal Revenue Code regulations require proof of eligible expenses using itemized receipts or other documentation showing the date of service, person for whom service was provided and description of the expense. Depending on the type of expense, documentation may come in the form of third party itemized statements or Explanation of Benefits.*

Schedule Your Appointment

https://enroll.americanfidelity.com/D9D6CA23

Point your smart phone camera at the QR code and open the link that appears.

Marine Zadourian
Sr Account Executive
CA License #0D47136
9000 Cameron Parkway
Oklahoma City, OK 73114
800-654-8489, Ext. 8562
marine.zadourian@americanfidelity.com

SB-33041-0120

American Fidelity Assurance Company
americanfidelity.com

Limitations, exclusions and waiting periods may apply.

VOYA Financial

City of Oxnard Retirement Plan

Through your employer's retirement program, you have access to a dedicated Voya Financial® team available to assist you with a variety of services. You can meet with your local Voya® financial professional(s) to review your retirement savings goals, investment strategies or other savings goals.

Your local Voya financial professional can help you:

- Review your plans for the future and compare them to how (and how much) you save.
- Design a financial analysis and follow it.
- Create action steps based on your personal goals.
- Provide ongoing assistance to help you as you work toward reaching your goals.
- Help you develop a budget for today's expenses and for living in retirement.

You can also learn more about your retirement distribution options and your retirement income potential, or schedule a no-obligation review of your overall retirement plan.

VoyaRetirementPlans.com

To get started, contact us today.

Jason Bahramian, IAR of Voya Financial Advisors, Inc.
1030 Nevada St., Ste. 203
Redlands, CA 92374
Tel: 310.938.5695
Email: JBahramian@voyafa.com

Consider this: What's a future without a plan?

Whether you're new to saving or an experienced investor, your workplace retirement plan is an important tool to help you realize your retirement goals:

- Save automatically
- Make changes anytime
- Help lower your taxable income
- Invest your way
- Take your money with you
- Access to online tools and resources, including Voya Learn™, our live and on-demand financial wellness education sessions.

CITY OF OXNARD CALIFORNIA

PLAN
INVEST
PROTECT

VOYA® FINANCIAL

VOYA Financial (continued)

It's easy to get started

The steps you take today will affect how you spend tomorrow. On your journey to retirement, do something good for yourself by planning ahead for the kind of future you envision. Start by setting a little aside regularly for the kind of retirement you can look forward to by enrolling in your employer's retirement savings plan.

1. Go to enroll.voya.com
2. Enter plan number
   664404
3. Enter verification number
   040115

Enroll Me™

5 reasons to enroll now

1. Make changes anytime
2. Save automatically
3. Help lower your taxable income
4. Invest your way
5. Take your money with you

For more info contact:

Jason Bahramian
1(310) 938-5695
jbahramian@voyafa.com

City of Oxnard 457(b) Deferred Compensation Plan

Not FDIC/NCUA/NCUSIF Insured | Not a Deposit of a Bank/Credit Union | May Lose Value | Not Bank/Credit Union Guaranteed | Not Insured by Any Federal Government Agency

Insurance products, annuities and funding agreements are issued by Voya Retirement Insurance and Annuity Company ("VRIAC"), Windsor, CT. VRIAC is solely responsible for its own financial condition and contractual obligations. Plan administrative services provided by VRIAC or Voya Institutional Plan Services LLC ("VIPS"). VIPS does not engage in the sale or solicitation of securities. All companies are members of the Voya® family of companies. **Securities distributed by Voya Financial Partners LLC (member SIPC) or third parties with which it has a selling agreement.** All products and services may not be available in all states.

Investment adviser representative and registered representative of, and securities and investment advisory services offered through Voya Financial Advisors, Inc. (member SIPC).

PLAN | INVEST | PROTECT

VOYA FINANCIAL

VOYA Financial (continued)

Did you know your employer-sponsored retirement plan offers online tools and resources to help you plan your financial future? Gain access to information about your account, including statements, fund performance, transaction history and alerts, as well as financial education and investment updates.

You will receive a unique Personal Identification Number (PIN) in the mail after your Plan account is set up. Your PIN is required to register and view your account online or to access your account information by phone.

First time users

VoyaRetirementPlans.com

View the website in Spanish! Select "Español" in the language selector at the bottom of the website to view all of your account information in Spanish.

1. Click *Register now.*
   - Select the way you would like to create your online access.
   - If you prefer to use the PIN option, but have not received or cannot locate your PIN, you can request a PIN on the website or by calling customer service.
2. Set up a unique username and password for use on the website and the Voya Retire mobile app.
3. Provide your mobile number or an alternate email address to ensure the security of your account. We will use this for the future recovery of your username or password, as needed, or if you login using a computer or device that is not recognized.

   HINT! Please retain your PIN. If using the phone services you will need that same Voya-issued PIN for detailed account information and to perform certain transactions. If helpful, you can customize your PIN through the automated system to something you will more easily remember.

Access your account on the go

Get the Voya Retire mobile app to check your account balance and much more on your smartphone*.

* Search Voya Retire in your mobile app store. You will log in with the same Username and Password used for the Plan website. If your device allows, you can establish fingerprint security.

Access your account by phone

1-800-584-6001

You can access your account by phone 24 hours a day, seven days a week. Keep in mind when calling you may need your PIN. If you've lost or misplaced your PIN, request a PIN reminder through the automated system or hold for a Customer Service Associate.

Not FDIC/NCUA/NCUSIF Insured | Not a Deposit of a Bank/Credit Union | May Lose Value | Not Bank/Credit Union Guaranteed | Not Insured by Any Federal Government Agency

Important Notices

No Surprises Act Notice

Our medical plans are subject to the No Surprises Act, which limits the amount covered persons may have to pay for some out-of-network surprise medical bills. More information about surprise billing requirements included under the No Surprises Act and similar state laws can be found on the medical insurance company's website or the Plan Sponsor's website. Additional information may be found in your Explanation of Benefits for any affected claims.

Discrimination is Against the Law

City of Oxnard complies with the applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics). City of Oxnard does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for pregnancy hospital stay (for delivery) for a mother and her newborn may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply to this minimum length of stay. Early discharge is permitted only if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA) Annual Notice

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. For more information, you should review the Summary Plan Description or call your Plan Administrator at 805-385-7473.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your individual CalPERS medical plan customer service number on the back of your medical ID card.

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

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

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with your individual CalPERS medical plan. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

Notice of Extended Coverage to Children Covered as Students

Michelle's Law generally extends eligibility for group health benefit plan coverage to a dependent child over age 26, who, as a condition of coverage, is enrolled in an institution of higher education. Please review the following information with respect to your dependent child's rights in the event student status is lost.

Michelle's Law requires the Plan to allow extended eligibility in some cases for a covered child over age 26, who would lose eligibility for Plan coverage due to loss of full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- *Dependent child means a child over age 26 who is a dependent of a plan participant and who is eligible under the terms of the Plan based on their student status and enrollment at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.*
- *Medically necessary leave of absence means a leave of absence or any other change in enrollment:*
  - of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury;
  - Which is medically necessary; and,
  - Which causes the dependent child to lose student status under the terms of the Plan.

The dependent child's treating physician must provide written certification of medical necessity (i.e., a certification that the dependent child suffers from a serious illness or injury that necessitates a leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- *One year after the first day of the leave of absence; or*
- *The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student).*

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

COBRA Continuation Coverage

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

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and 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 does not 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 are an employee, you will become a Qualified Beneficiary if you lose 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 are the spouse of an employee, you will 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 their gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or,
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- The parent-employee dies;
- The parent-employee's employment ends for any reason other than their 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 of a Qualifying Event:

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

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

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

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted to the Plan Administrator.

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

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

Important Notices (continued)

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

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

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

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), 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.

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

IF YOU HAVE QUESTIONS

For more information about the Marketplace, visit www.healthcare.gov.

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), has jurisdiction with respect to the COBRA continuation coverage requirements of the Public Health Service Act (PHSA) that apply to state and local government employers, including counties, municipalities, public school districts, and the group health plans that they sponsor (Public Sector COBRA). COBRA can be a daunting and complex area of federal law. If you have any questions or issues regarding Public Sector COBRA, you may contact the Plan Administrator or email HHS at phig@cms.hhs.gov.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

Important Notices (continued)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is to be made on the date it is sent to the Plan or Plan Administrator.

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

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including your spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

Important Notices (continued)

If you declined coverage while Medicaid or the Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

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

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

For information about Special Enrollment Rights, please contact:

Sonia Rosales
Human Resources Technician
Sonia.rosales@oxnard.org

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

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

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

- **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 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.**
- **CalPERS has determined that the prescription drug coverage offered by CalPERS Medical Plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current City of Oxnard coverage will not be affected. If you keep this coverage and elect Medicare, the City of Oxnard coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current City of Oxnard coverage, be aware that you and your dependents will be able to get this coverage back.

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

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

Important Notices (continued)

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

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

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

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

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

REMEMBER

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

Date:	September 1, 2023
Name of Entity / Sender:	City of Oxnard
Contact:	Sonia Rosales
Address:	300 W. Third Street Oxnard, CA 93030
Phone:	805-385-7473

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

City of Oxnard Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Sonia Rosales, 805-385-8352.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about City of Oxnard in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away.

Open Enrollment for health insurance coverage through Covered California will begin on November 1, 2023, and end on January 31, 2024. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com or KeenanDirect at 855-653-3626 or www.KeenanDirect.com.

Open Enrollment for most other states begins on November 1 and closes on January 15 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.healthcare.gov.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 8.39% (for 2024) of your household income for the year, then that coverage for you is not Affordable. Affordability for dependent family members is determined separately and is based on the total cost of family coverage. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

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

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

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

STATES WITH INDIVIDUAL MANDATE

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Important Notices (continued)

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com. The information is numbered to correspond to the Marketplace application.

3. Employer name City of Oxnard	**4. Employer Identification Number (EIN)** 95-60000756	
5. Employer address 300 West 3rd Street	**6. Employer phone number** 805-385-8352	
7. City Oxnard	**8. State** CA	**9. ZIP code** 93030
10. Who can we contact about employee health coverage at this job? Sonia Rosales, Human Resources Technician		
11. Phone number (if different from above)	**12. Email address** Sonia.rosales@oxnard.org	

As your employer, we offer coverage that meets the minimum value standard to the employees as described in this Guide. The coverage offered to you meets the minimum value standard and the cost of this coverage to you is intended to be affordable based on employee wages.

Important Notices (continued)

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 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 866-444-EBSA (3272).

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

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHIP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
800-221-3943 | TTY: Colorado relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
800-359-1991 | TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 855-692-6442

FLORIDA – Medicaid
Website:
http://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp/
Phone: 678-564-1162, press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 800-457-4584IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888-346-9562

Important Notices (continued)

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 800-792-4884
HIPPA Phone: 800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 877-524-4718
Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 888-342-6207 (Medicaid hotline) or
855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 800-862-4840 | TTY: Massachusetts relay 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 800-657-3739

MISSOURI – Medicaid
Website:
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov/
Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
HIPP Program Toll-Free Phone: 800-852-3345, ext. 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: 800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888-365-3742

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 888-828-0059

Important Notices (continued)

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877-543-7669

VERMONT – Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid Phone: 800-432-5924
CHIP Phone: 800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-Free Phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

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

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

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

Glossary

Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, covering preventive care without cost-sharing, etc, among other requirements.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Brand Name Drug

The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

The Consolidated Omnibus Budget Reconciliation Act allows people who lose their jobs to continue their employer-sponsored insurance coverage for up to 18 months.

Children's Health Insurance Program (CHIP)

The government program that provides free or low-cost health coverage for children up to age 19 in families whose income is too high to qualify for Medicaid but too low to afford private insurance. CHIP covers U.S. citizens and eligible immigrants. In some states, CHIP covers pregnant people. CHIP goes by different names in some states.

Claim

A request for payment that you or your health care provider submits to your health insurer to be paid or reimbursed for items or services you have received. Most often, you will not be responsible for making claim requests. Usually, billing and claims specialists employed by the health care provider (e.g. primary care office, hospital) will make the claim on your behalf.

Coinsurance

A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)

A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Comprehensive Coverage

A health insurance plan that covers the full range of care that you may need. This may include preventive services (like flu shots), physical exams, prescription drugs, and doctor or hospital care.

Deductible

The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Formulary

A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Generic Drug

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)

High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

Glossary (continued)

Health Savings Account (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. State taxes may apply. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Health Reimbursement Arrangements (HRAs)

Unlike HSAs, only an employer may fund an HRA and the funds revert back to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs, and they may be paired with either high-deductible plans or traditional health plans.

In-Network

Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Out-of-Pocket Maximum

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Out-Of-Network

A health plan may not cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-Of-Pocket Limit

The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including co-payments and co-insurance.

Plan Year

The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Premium

The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

Preventive Care

Health care services you receive when you are not sick or injured— so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

Qualifying Life Event

A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include moving to a new state, certain changes in your income, and changes in your family size.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

CLICK HERE to watch a video on Benefits Key Terms Explained