EMPLOYEE BENEFITS GUIDE

CITY OF OAKLAND
FULL-TIME & PERMANENT PART-TIME EMPLOYEES

JANUARY 1, 2026 - DECEMBER 31, 2026

Employee Benefits Guide 2026

FULL-TIME & PERMANENT PART-TIME EMPLOYEES

General Information

Core Benefits

Other Benefits

Miscellaneous

Click this icon in your benefits guide to watch a video explaining the associated topic.

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 43 for more details.

The information in this brochure is a general outline of the benefits offered under the City of Oakland'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.

Employee Benefits Package Overview

- CalPERS Medical
- Dental
- Vision
- Medical Waiver Plan – Cash-In-Lieu
- Flexible Spending Accounts
- Commuter Benefits
- Group & Supplemental Life Insurance
- Employee Assistance Program (EAP)
- Guaranteed Ride Home (GRH)
- Pension Benefits
- Deferred Compensation

Contact Information

Benefits Contacts

You may contact the below benefit carriers or visit the following websites to confirm eligibility and verify coverage:

Employee Benefits Program	Benefits Staff	Contact Information
Benefits Supervisor	**Tami Honda**	510-238-6891 thonda@oaklandca.gov
Benefits Enrollment Questions New Hire Benefit Enrollment General Benefit Questions	**Benefits Unit**	BenefitsAdmin@oaklandca.gov
COBRA	**Denise Carter**	510-238-7446 dcarter@oaklandca.gov
	Administrator: Navia Benefits Solutions	877-920-9675 cobra@naviabenefits.com
Deferred Compensation	**Nancy Agaiby: Mission Square** (Investment Option Inquiry Only)	202-759-7277 nagaiby@missionsq.org
	Jeanette Delgado	510-238-7445 jdelgado@oaklandca.gov
	Benefits Unit	Benefitsadmin@oaklandca.gov
• Medical • Dental • Vision • Flexible Spending Accounts *(Health Care FSA and Dependent Care FSA)* • Commuter Benefits	**Lisa Lavatai**	510-238-6769 llavatai@oaklandca.gov Benefitsadmin@oaklandca.gov
	Adrienne Cooper	510-238-6474 acooper2@oaklandca.gov Benefitsadmin@oaklandca.gov
Other Benefits		
• Life Insurance *(Non-Sworn)* The Hartford	**Denise Carter**	510-238-7446 dcarter@oaklandca.gov
Guaranteed Ride Home	**Tami Honda**	510-238-6891 thonda@oaklandca.gov

Contact Information (continued)

Risk Contacts

Employee Benefits Program	Risk Management Staff	Contact Information
Risk Administration		
• Administrative Support • Safety Shoe Program, Health and Wellness • State Disability *(Local 1021)* • Unemployment (EDD)	Erika Turner	510-238-7660 eturner@oaklandca.gov
	Adrienne Cooper	510-238-6474 acooper2@oaklandca.gov
• Employee Assistance Program • Threat Assessment • CAL/OSHA Programs	Greg Elliott	510-238-4993 gelliott@oaklandca.gov
• Ergonomics • Safety, Health & Wellness • VDT Glasses	Lana Chan	510-238-7971 LChan2@oaklandca.gov
• Risk – Contracts & Insurance	Michael Bailey	510-986-2898 mbailey@oaklandca.gov
• Workers' Compensation • Fair Employment Housing Act (FEHA) • Americans with Disabilities Act (ADA)	Donella Williams	510-238-6488 dwilliams3@oaklandca.gov
• Family Medical Leave Act (FMLA) • Pregnancy Disability and Bonding • Paid Family Leave *(non sworn)*	Leave Unit	familymedicalleave@oaklandca.gov

Contact Information (continued)

You may also contact the below benefit carriers or visit the following websites to confirm eligibility and verify coverage:

Employee Benefits Program	Phone Number	Web Site
Medical		
• CalPERS	888-225-7377	https://my.calpers.ca.gov
Dental		
• Delta Dental – Group No. 00558	800-765-6003	www.deltadentalins.com
• DeltaCare – Group No. 76003	800-422-4234	www.deltadentalins.com
Vision		
• Vision Service Plan – Group No. 00 826401	800-877-7195	www.vsp.com
Health Care and Day Care FSA		
• Navia Health Care FSA & Day Care FSA	800-669-3539	https://www.naviabenefits.com **or** customerservice@naviabenefits.com
COBRA Administration		
• Navia COBRA	877-920-9675	cobra@naviabenfits.com
Commuter Benefits		
• GoNavia Commuter Benefits	800-669-3539	https://www.naviabenefits.com
• Guaranteed Ride Home Program	510-433-0320	ridehome@alamedactc.org
Life and Disability Insurance		
• The Hartford - Life Insurance & Disability Insurance Long & Short Term	800-523-2233	www.thehartford.com
Employee Assistance Program (EAP)		
• Claremont EAP	800-834-3773	www.claremonteap.com
Deferred Comp		
• Mission Square	800-669-7400	https://www.icmarc.org/city-of-oakland-457-plan.html

2026 Payroll Processing and Holiday Calendar

January

1 New Year's Day

19 Martin Luther King Jr. Day

February

16 President's Day

March

31 Cesar Chavez Day

May

25 Memorial Day

June

19 Juneteenth National Independence Day

July

4 Independence Day

September

7 Labor Day

9 Admissions Day (HVA)*

November

11 Veteran's Day (HVA)*

26 Thanksgiving Day

27 Day after Thanksgiving Day

December

25 Christmas Day

*If applicable

JANUARY

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FEBRUARY

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MARCH

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JUNE

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SEPTEMBER

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OCTOBER

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NOVEMBER

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29	30					

DECEMBER

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20	21	22	23	24	25	26
27	28	29	30	31		

Pay Period Ends

Pay Dates

Holidays

Holidays and Pay Period Ends

2026 Holiday Schedule

2026 Holiday	Date		Day of the Week
	Month	Day	
New Year's Day	January	01	Wednesday
Dr. Martin Luther King, Jr. Day	January	19	Monday
President's Day	February	16	Monday
Cesar Chavez Day	March	31	Tuesday
Memorial Day	May	25	Monday
Juneteenth National Independence Day	June	19	Friday
Independence Day	July	04	Saturday
Labor Day	September	07	Monday
Admissions Day	September	09	Wednesday
Veterans Day	November	11	Wednesday
Thanksgiving Day	November	26	Thursday
Day After Thanksgiving	November	27	Friday
Christmas Day	December	25	Friday

Holidays that fall on Saturday, Sunday or Regular Day Off

If a designated holiday falls upon a normal day off which is either a Saturday; as to an employee who works a Monday through Friday workweek, or the first day off a normal scheduled two day off, as to an employee whose workweek is one other than Monday through Friday, shall thereafter receive one (1) additional day of vacation.

If a designated holiday falls upon a normal day off which is either a Sunday; as to an employee who works a Monday through Friday workweek, or the second day off a normal scheduled two day off, as to an employee whose workweek is one other than Monday through Friday, shall receive the next following day off.

Christmas Eve and New Year's Eve

An employee whose regular workweek is Monday through Friday, and December 24th and December 31st occur on a Saturday or Sunday, or employees that are required to work on both December 24th and December 31st shall be entitled to one of the following:

- One half of the work-shift as paid time off on both the Friday preceding Christmas Eve and the Friday preceding New Year's Eve (when December 24th and December 31st falls on a Saturday or Sunday) or One half of the work-shift on both the above days; ***or***
- One full work-shift as paid time off on either the Friday preceding Christmas Eve or the Friday preceding New Year's Eve (when December 24th and December 31st falls on a Saturday or Sunday) or One full work-shift as paid time off on either of the above days.

Service Employees International Union (SEIU) Local 1021

- One half of the work shift as paid time off on two of the following: December 24th, December 26th, December 31st, or January 2nd; ***or***
- One full work shift as paid time off on December 24th, December 26th, December 31st, or January 2nd.

Rates: Full-Time Employees

Monthly Medical Plan Rates for Eligible Permanent Full-Time Employees

Effective January 1, 2026

Medical Plans	REGION 1 Counties: Alameda, Alpine, Amador, Butte, Calavares, Colusa, Contra Costa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba					
	Monthly Premium Cost			Monthly Employee Contribution*		
	Employee Only	Employee + 1	Employee + 2 or more	Employee Only	Employee + 1	Employee + 2 or more
Anthem Select HMO	$1,336.29	$2,672.58	$3,474.35	$167.43	$334.86	$435.31
Anthem Traditional HMO	$1,612.08	$3,224.16	$4,191.41	$443.22	$886.44	$1,152.37
Blue Shield Access+ HMO	$1,301.95	$2,603.90	$3,385.07	$133.09	$266.18	$346.03
Blue Shield Access+ EPO	$1,301.95	$2,603.90	$3,385.07	$133.09	$266.18	$346.03
Blue Shield Trio	$1,166.58	$2,333.16	$3,033.11	$0.00	$0.00	$0.00
Kaiser (CA) HMO	$1,168.86	$2,337.72	$3,039.04	$0.00	$0.00	$0.00
PERS Gold	$1,120.58	$2,241.16	$2,913.51	$0.00	$0.00	$0.00
PERS Platinum	$1,670.14	$3,340.28	$4,342.36	$501.28	$1,002.56	$1,303.32
PORAC *(POLICE ONLY)*	$1,063.00	$2,418.00	$3,027.00	$0.00	$80.28	$0.00
United HealthCare HMO	$1,290.06	$2,580.12	$3,354.16	$121.20	$242.40	$315.12
United HealthCare Harmony HMO	$1,133.09	$2,266.18	$2,946.03	$0.00	$0.00	$0.00
Western Health Advantage	$969.58	$1,939.16	$2,520.91	$0.00	$0.00	$0.00

Medical Plans	REGION 2 Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, San Diego, San Luis Obispo, Santa Barbara, Tulare, and Ventura					
	Monthly Premium Cost			Monthly Employee Contribution*		
	Employee Only	Employee + 1	Employee + 2 or more	Employee Only	Employee + 1	Employee + 2 or more
Anthem Select HMO	$1,016.32	$2,032.64	$2,642.43	$0.00	$0.00	$0.00
Anthem Traditional HMO	$1,158.26	$2,316.52	$3,011.48	$0.00	$0.00	$0.00
Blue Shield Access+ HMO	$1,052.89	$2,105.78	$2,737.51	$0.00	$0.00	$0.00
Blue Shield Access+ EPO	$1,052.89	$2,105.78	$2,737.51	$0.00	$0.00	$0.00
Blue Shield Trio	$936.58	$1,873.16	$2,435.11	$0.00	$0.00	$0.00
Health Net Salud y Mas	$879.57	$1,759.14	$2,286.88	$0.00	$0.00	$0.00
Kaiser (CA) HMO	$987.69	$1,975.38	$2,567.99	$0.00	$0.00	$0.00
PERS Gold	$956.28	$1,912.56	$2,486.33	$0.00	$0.00	$0.00
PERS Platinum	$1,426.24	$2,852.48	$3,708.22	$257.38	$514.76	$669.18
PORAC *(POLICE ONLY)*	$1,057.00	$2,127.00	$2,708.00	$0.00	$0.00	$0.00
Sharp	$916.20	$1,832.40	$2,382.12	$0.00	$0.00	$0.00
United HealthCare HMO	$950.99	$1,901.98	$2,472.57	$0.00	$0.00	$0.00
United HealthCare Harmony HMO	$857.14	$1,714.28	$2,228.56	$0.00	$0.00	$0.00

*Sworn Fire employees pay an additional $5.00 per pay period contribution for all plans.

*****IMPORTANT NOTE - You must verify the plan is available in your home or work zip code area.*****

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.

Rates: Full-Time Employees (continued)

Monthly Medical Plan Rates for Eligible Permanent Full-Time Employees

Effective January 1, 2026

Medical Plans	REGION 3 Los Angeles, Riverside, San Bernardino					
	Monthly Premium Cost			Monthly Employee Contribution*		
	Employee Only	Employee + 1	Employee + 2 or more	Employee Only	Employee + 1	Employee + 2 or more
Anthem Select HMO	$962.68	$1,925.36	$2,502.97	$0.00	$0.00	$0.00
Anthem Traditional HMO	$1,128.53	$2,257.06	$2,934.18	$0.00	$0.00	$0.00
Blue Shield Access+ HMO	$917.91	$1,835.82	$2,386.57	$0.00	$0.00	$0.00
Blue Shield Trio	$852.56	$1,705.12	$2,216.66	$0.00	$0.00	$0.00
Health Net Salud y Mas	$740.11	$1,480.22	$1,924.29	$0.00	$0.00	$0.00
Kaiser (CA) HMO	$969.05	$1,938.10	$2,519.53	$0.00	$0.00	$0.00
PERS Gold	$960.03	$1,920.06	$2,496.08	$0.00	$0.00	$0.00
PERS Platinum	$1,431.81	$2,863.62	$3,722.71	$262.95	$525.90	$683.67
PORAC *(POLICE ONLY)*	$1,057.00	$2,127.00	$2,708.00	$0.00	$0.00	$0.00
United HealthCare HMO	$870.76	$1,741.52	$2,263.98	$0.00	$0.00	$0.00
United HealthCare Harmony HMO	$765.51	$1,531.02	$1,990.33	$0.00	$0.00	$0.00

Medical Plans	REGION - OUT OF STATE					
	Monthly Premium Cost			Monthly Employee Contribution*		
	Employee Only	Employee + 1	Employee + 2 or more	Employee Only	Employee + 1	Employee + 2 or more
Kaiser Out of State	$1,398.96	$2,797.92	$3,637.30	$230.10	$460.20	$598.26
PERS Platinum	$1,410.29	$2,820.58	$3,666.75	$241.43	$482.86	$627.71
PORAC *(POLICE ONLY)*	$1,206.00	$2,448.00	$2,900.00	$37.14	$110.28	$0.00

*Sworn Fire employees pay an additional $5.00 per pay period contribution for all plans.

*****IMPORTANT NOTE - You must verify the plan is available in your home or work zip code area.*****

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Rates: Full-Time Employees (continued)

Dental & Vision Rates

Benefit Plan	Employee Only	Employee + 1	Employee + Family
Delta Dental PPO			
• City's Contribution: $115.28 • Total Premium Cost: $115.28	$0.00	$0.00	$0.00
DeltaCare HMO			
• City's Contribution: $34.99 • Total Premium Cost: $34.99	$0.00	$0.00	$0.00
Vision Service Plan			
• Employee Only – City's Contribution: $8.41 – Total Premium Cost: $8.41	$0.00	$0.00	$0.00
• Employee + 1 – City's Contribution: $16.82 – Total Premium Cost: $16.82	$0.00	$0.00	$0.00
• Employee + Family – City's Contribution: $19.75 – Total Premium Cost: $19.75	$0.00	$0.00	$0.00

Rates: Permanent Part-Time Employees

Monthly Medical Plan Rates for Eligible Permanent Part-Time Employees

Effective January 1, 2026

Medical Plans	REGION 1 Counties: Alameda, Alpine, Amador, Butte, Calavares, Colusa, Contra Costa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba					
	Monthly Premium Cost			Monthly Employee Contribution		
	Employee Only	Employee + 1	Employee + 2 or more	Employee Only	Employee + 1	Employee + 2 or more
Anthem Select HMO	$1,336.29	$2,672.58	$3,474.35	$459.64	$919.29	$1,195.07
Anthem Traditional HMO	$1,612.08	$3,224.16	$4,191.41	$735.43	$1,470.87	$1,912.13
Blue Shield Access+ HMO	$1,301.95	$2,603.90	$3,385.07	$425.30	$850.61	$1,105.79
Blue Shield Access+ EPO	$1,301.95	$2,603.90	$3,385.07	$425.30	$850.61	$1,105.79
Blue Shield Trio	$1,166.58	$2,333.16	$3,033.11	$289.93	$579.87	$753.83
Kaiser (CA) HMO	$1,168.86	$2,337.72	$3,039.04	$292.21	$584.43	$759.76
PERS Gold	$1,120.58	$2,241.16	$2,913.51	$243.93	$487.87	$634.23
PERS Platinum	$1,670.14	$3,340.28	$4,342.36	$793.49	$1,586.99	$2,063.08
United HealthCare HMO	$1,290.06	$2,580.12	$3,354.16	$413.41	$826.83	$1,074.88
United HealthCare Harmony HMO	$1,133.09	$2,266.18	$2,946.03	$256.44	$512.89	$666.75
Western Health Advantage	$969.58	$1,939.16	$2,520.91	$92.93	$185.87	$241.63

Medical Plans	REGION 2 Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, San Diego, San Luis Obispo, Santa Barbara, Tulare, and Ventura					
	Monthly Premium Cost			Monthly Employee Contribution		
	Employee Only	Employee + 1	Employee + 2 or more	Employee Only	Employee + 1	Employee + 2 or more
Anthem Select HMO	$1,016.32	$2,032.64	$2,642.43	$139.67	$279.35	$363.15
Anthem Traditional HMO	$1,158.26	$2,316.52	$3,011.48	$281.61	$563.23	$732.20
Blue Shield Access+ HMO	$1,052.89	$2,105.78	$2,737.51	$176.24	$352.49	$458.23
Blue Shield Access+ EPO	$1,052.89	$2,105.78	$2,737.51	$176.24	$352.49	$458.23
Blue Shield Trio	$936.58	$1,873.16	$2,435.11	$59.93	$119.87	$155.83
Health Net Salud y Mas	$879.57	$1,759.14	$2,286.88	$2.92	$5.85	$7.60
Kaiser (CA) HMO	$987.69	$1,975.38	$2,567.99	$111.04	$222.09	$288.71
PERS Gold	$956.28	$1,912.56	$2,486.33	$79.63	$159.27	$207.05
PERS Platinum	$1,426.24	$2,852.48	$3,708.22	$549.59	$1,099.19	$1,428.94
Sharp	$916.20	$1,832.40	$2,382.12	$39.55	$79.11	$102.84
United HealthCare HMO	$950.99	$1,901.98	$2,472.57	$74.34	$148.69	$193.29
United HealthCare Harmony HMO	$857.14	$1,714.28	$2,228.56	$0.00	$0.00	$0.00

IMPORTANT NOTE - You must verify the plan is available in your home or work zip code area.

Rates: Permanent Part-Time Employees (continued)

Monthly Medical Plan Rates for Eligible Permanent Part-Time Employees

Effective January 1, 2026

Medical Plans	REGION 3 Los Angeles, Riverside, San Bernardino					
	Monthly Premium Cost			Monthly Employee Contribution		
	Employee Only	Employee + 1	Employee + 2 or more	Employee Only	Employee + 1	Employee + 2 or more
Anthem Select HMO	$962.68	$1,925.36	$2,502.97	$86.03	$172.07	$223.69
Anthem Traditional HMO	$1,128.53	$2,257.06	$2,934.18	$251.88	$503.77	$654.90
Blue Shield Access+ HMO	$917.91	$1,835.82	$2,386.57	$41.26	$82.53	$107.29
Blue Shield Trio	$852.56	$1,705.12	$2,216.66	$0.00	$0.00	$0.00
Health Net Salud y Mas	$740.11	$1,480.22	$1,924.29	$0.00	$0.00	$0.00
Kaiser (CA) HMO	$969.05	$1,938.10	$2,519.53	$92.40	$184.81	$240.25
PERS Gold	$960.03	$1,920.06	$2,496.08	$83.38	$166.77	$216.80
PERS Platinum	$1,431.81	$2,863.62	$3,722.71	$555.16	$1,110.33	$1,443.43
United HealthCare HMO	$870.76	$1,741.52	$2,263.98	$0.00	$0.00	$0.00
United HealthCare Harmony HMO	$765.51	$1,531.02	$1,990.33	$0.00	$0.00	$0.00

IMPORTANT NOTE - You must verify the plan is available in your home or work zip code area.

Monthly Dental and Vision Plan Rates for Eligible Permanent Part-Time Employees

Plan	Monthly Premium Cost			Monthly Employee Contribution		
	Employee Only	Employee + 1	Employee + 2 or more	Employee Only	Employee + 1	Employee + 2 or more
Delta Dental PPO	$117.67	$117.67	$117.67	$29.42	$29.42	$29.42
DentalCare HMO	$34.99	$34.99	$34.99	$8.75	$8.75	$8.75
VSP Vision	$8.41	$16.82	$19.75	$2.10	$4.21	$4.94

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Introduction

As City of Oakland 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 Oakland.

In order to activate your benefits, complete and submit the following:

- CalPERS Beneficiary Designation Form
- City of Oakland Employee Benefits Record (EBR)

Optional Benefit Forms

- Flexible Spending Plan Enrollment form
- Cafeteria Plan Election form (Medical Waiver)
- Optional Life & Voluntary AD&D Insurance form
- Spouse and child coverage available to employees who are enrolled
- Evidence of Insurability form (Required only if enrolling in Life Insurance coverage that exceeds $100,000)
- Pre-designation of Personal Physician

You have 60 days from the date of your initial appointment to enroll or decline coverage for yourself and eligible family members. Benefits will begin on the 1st of the month after you submit your paperwork and appropriate documentation to the Human Resources Management Risk Benefits Division. If you do not enroll during the initial 60 days and have not experienced a qualifying life event, your enrollment will be subject to a 90-day waiting period or the following Open Enrollment period, whichever comes first.

Any questions you may have regarding the enclosed information can be referred to the corresponding representative listed in your "Benefits Telephone Directory" found at the beginning of this guide or emailed to BenefitsAdmin@oaklandca.gov.

Benefit Choices

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

Eligibility

Employees

The City of Oakland offers Medical, Dental, Vision, Group Life/AD&D, and Supplemental Coverage to full-time and permanent part-time employees and their eligible dependents.

Employees may opt out of coverage with proof of other group coverage.

To elect the medical waiver plan you must:

- Complete the Medical Wavier Form
- Complete the Employee Benefits Record Form
- Provide proof of other coverage in the form of a letter. Insurance cards are not accepted. Medical Waiver Premium

The Medical Waiver Premium amounts are based off your represented unit. Please refer to your MOU for premium amounts.

Dependents

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

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

For purposes of medical plan coverage, the following dependents are eligible:

- A spouse who is not currently enrolled as an employee in a Public Employees Retirement System (PERS)-administered medical plan
- A registered domestic partner
- Certified disabled child age 26 or older
- Child (up to age 26) for whom you have a parent-child relationship (restrictions apply)
- Adopted Child

For purposes of non-sworn dental and vision plan coverage, eligible dependents are as follows:

- A spouse
- Child (up to age 19, or age 25 with student status) for whom you have a parent-child relationship (restrictions apply)
- Adopted Child
- Certified disabled child, age 25 or older
- A registered domestic partner of an employee

Active Employment

Employees who are eligible to participate in the medical and dental group insurance plans are full-time employees, permanent part-time employees, and limited-duration employees with an appointment of six (6) months or longer.

Employees who are eligible to participate in the vision plan are all non-sworn unrepresented employees and represented employees as provided for in the individual Memoranda of Understanding.

Enrollment

Open Enrollment

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

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

Enrollment Instructions

When you are hired, you will receive this Employee Benefits Guide describing your different benefits. Additional brochures are available at the City of Oakland. Your coverage will start on the first of the month following the date your enrollment paperwork is received **(provided you submit your enrollment forms within 60 days of the enrollment period)**.

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

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

The following forms must be provided in order to commence your benefits (please attach required copies of documents for dependents):

- Employee Benefits Record (EBR) form
- CalPERS Beneficiary Designation form

Online enrollment is required for Parking and Transit Programs, and the Guaranteed Ride Home.

Please submit your forms and required documents to the Benefits Unit, 150 Frank Ogawa Plaza, 2nd Floor front counter or you can fax your forms to 510-238-6560.

All benefits information and forms can be found on the City of Oakland website at www.oaklandca.gov/benefits or at 150 Frank H. Ogawa Plaza, 2nd Floor (Human Resources Front Counter) Oakland, CA 94612.

Change in Beneficiaries

Certain events in your life such as marriage, divorce, or a death in the family can affect who you name as your designated beneficiary for certain benefits. You may change your beneficiary(ies) at any time. If you wish to do so, you can obtain beneficiary forms from the City's Benefits webpage at https://www.oaklandca.gov/documents/benefit-forms

You must designate a beneficiary for:

- Deferred Compensation
- Life Insurance
- Retirement - CalPERS

Changes in Coverage

Qualifying Events

You may experience certain events during the plan year that would allow you to change you or your dependent's medical coverage. If any of the following events occur, you must change your benefit coverage within 60 days of the event:

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

Special Enrollment Rights as Provided by HIPAA

- You initially declined coverage under the plan because you had coverage under another plan and subsequently incurred a loss of coverage under the other plan.
- Occurrence of certain events such as birth, adoption, placement for adoption or marriage.

Coverage When Leaving the City

When your employment with the City ends, your medical coverage will continue through the end of the following month in which you terminate employment. For example, if your last day of employment is June 3rd, your medical coverage continues through July 31st. Dental and vision coverage continue through the end of the month in which your employment ends. Commuter benefits, Flexible Spending Accounts (FSA), and life insurance continue through your last day of employment. You will have the option to enroll in COBRA continuation medical, dental, vision and/or FSA coverage. A COBRA continuation package will be sent to your home. A Notice of Conversion and/or Portability for life insurance will also be sent to your home.

2026 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 view 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
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/benefits/

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

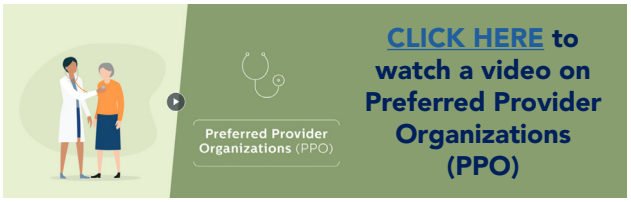
Peace Officers Research Association of California[1]
800-655-6397
www.ibtofporac.org/

PERS Gold and PERS Platinum
855-633-4436
includedhealth.com/calpers

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

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.

Medical – CalPERS

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

Health Maintenance Organizations (HMOs)

HMOs allow you to receive comprehensive coverage at set prices, called copays.

- **Doctors/Other Medical Care Providers.** You can only use doctors, hospitals, and pharmacies that participate in the HMO network. Doctors who participate in the HMO network are called in- network providers. There is no coverage if you go to out-of-network providers, except for emergency services.
- **Annual Deductible.** You don't need to pay an annual deductible before the plan begins to pay for a portion of covered medical services.
- **Copays.** When you receive medical care, you pay a set dollar amount called a copay.
- **Annual Out-of-Pocket Maximum.** The HMO plans include an annual out-of-pocket maximum. This is the maximum amount you must pay out of your own pocket for copays during the plan year. Once you reach the out-of-pocket maximum, the plan pays 100% of covered charges for the remainder of the plan year.

Preferred Provider Organization (PPO)

The PPO plan allows you to use any provider you choose.

- **Doctors/Health Care Providers.** You can choose any doctor you want, and you can go to any hospital or pharmacy. However, you'll pay less when you use a provider or facility that participates in-network.
- **Preventive Care.** Preventive care is 100% covered when you use in-network providers. Visit healthcare.gov/preventive-care-benefits/ for a complete list of preventive care benefits required to be covered at 100% per the Affordable Care Act.
- **Annual Deductible.** You generally pay an annual deductible before the plan begins to pay for a portion of covered medical services.

CLICK HERE to watch a video on PPO vs HMO

- **Paying for Care. When you receive medical care, there are two ways you pay for services:**
  - **Copays.** When you go to an in-network doctor for an office visit, go to the emergency room, or pick up a prescription, you pay a set dollar amount called a copay. (You may need to pay the annual deductible first before the copay applies.)
  - **Coinsurance.** When you receive any other medical services, you pay a percentage of the cost of the service and the plan pays the remaining percentage. This is called coinsurance. (You will need to pay the annual deductible first before coinsurance applies.)
- **Annual Out-of-Pocket Maximum.** The PPO includes an out-of-pocket maximum. This is the maximum amount you must pay out of your own pocket (under the applicable coinsurance percentage) after meeting the deductible. Once you reach the out-of-pocket maximum, the plan pays 100% of in- network charges for the remainder of the plan year. Please note that your out-of-pocket maximum will be lower when you use in-network providers.

2026 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. All benefits subject to regulatory approval.

Benefits	Anthem Blue Cross Select HMO Traditional HMO	Blue Shield Access+ HMO EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	United-Healthcare Signature-Value Alliance & Harmony	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 *(including Mental Health and Substance Abuse)*							
• 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
• Outpatient Facility/Surgery Services	No Charge	No Charge	No Charge	$15	No Charge	No Charge	No Charge
Emergency Services							
• Emergency Room Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Emergency *(copay waived if admitted as an inpatient or for observation as an outpatient)*	$50	$50	$50	$50	$50	$50	$50
• Non-Emergency *(copay waived if admitted as an inpatient or for observation as an outpatient)*	$50	$50	$50	$50	$50	$50	$50
Physician Services *(including Mental Health and Substance Abuse)*							
• 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 Visits	$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	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

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.

2026 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. All benefits subject to regulatory approval.

Benefits	Anthem Blue Cross Select HMO Traditional HMO	Blue Shield Access+ HMO EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	United-Healthcare Signature-Value Alliance & Harmony	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
• Retail Pharmacy *(30-day supply)*	Tier 1: $5 Tier 2: $20 Tier 3: $50	Tier 1: $5 Tier 2: $20 Tier 3: $50 Tier 4: $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 Pharmacy *(90-day supply)*	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100 Tier 4: $60 (Retail Preferred Pharmacy Maintenance Medications)	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	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100
• 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 Tier 4: $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
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

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2026 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. All benefits subject to regulatory approval.

Benefits	Anthem Blue Cross Select HMO Traditional HMO	Blue Shield Access+ HMO EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	United-Healthcare Signature-Value Alliance & Harmony	Western Health Advantage HMO
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)
Pregnancy & Maternity Care	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

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2026 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. All benefits subject to regulatory approval.

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 [1,3]	$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 *(including Mental Health and Substance Abuse)*						
• Deductible *(per admission)*	N/A		$250 (copay)		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	$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 inpatient deductible (max. $500) or family deductible (max. $1,000). Refer to EOC for details.

2 Coinsurance waived for deliveries if enrolled in Included Health's Maternity Program by the 24th week of pregnancy. For deliveries after April 2026, member must be enrolled by January 1, 2026.

3 Deductible is not transferable between PERS Gold and PERS Platinum.

4 Of the allowable amount as defined in the EOC.

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.

2026 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. All benefits subject to regulatory approval.

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Physician Services *(including Mental Health and Substance Abuse)*						
• Office Visits *(copay for each service provided)*	$35 [1,2]	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 matched 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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2026 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. All benefits subject to regulatory approval.

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	
• 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 Formulary: $25 Non-Formulary: $45 Compound: $45	
• Retail Pharmacy *(90-day supply)*	Tier 1: $10 Tier 2: $40 Tier 3: $100		Tier 1: $10 Tier 2: $40 Tier 3: $100		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 Formulary: $40 Non-Formulary: $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)			

1 Of the allowable amount as defined in the EOC.

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2026 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. All benefits subject to regulatory approval.

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Infertility Testing/ Treatment	50%		50%		50%	50% [2]
Occupational / Physical / Speech Therapy						
• Inpatient *(hospital or skilled nursing facility)*	No Charge		No Charge		20%	20% [2]
• Outpatient *(office and home visits)*	20%	40% (Occupational therapy: 20%)	10%	40% (Occupational therapy: 10%)	20%	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]	20%	20% [2]
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)	
Chiropractic	$15/Visit	40% [2]	$15/Visit	40% [2]	20%	20% [2]
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)	
Pregnancy & Maternity Care	20% [3]	40%	10%	40%	80%	80%

1 $35 for specialist visit.

2 Of the allowable amount as defined in the EOC.

3 Coinsurance waived for deliveries if enrolled in Included Health's Maternity Program by the 24th week of pregnancy. For deliveries after April 2026, member must be enrolled by January 1, 2026.

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

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

DeltaCare USA

Delta Care USA is our prepaid plan that features set copayments, no annual deductibles and no maximums for covered benefits. In most states, enrollees must select a primary care dentist in the DeltaCare USA network from whom they receive treatment as in a traditional dental HMO.

Delta Dental PPO

Delta Dental PPO, our preferred provider organization (PPO) plan, provides access to the largest PPO dentist network in the U.S. Delta Dental PPO 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 (continued)

DeltaCare USA

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

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 non-Delta Dental PPO Dentist.

Plan Benefits	DeltaCare USA	Delta Dental PPO	
		In-Network	Out-of-Network
General Plan Information			
• Annual Deductible			
– Individual	$0	$25	$25
– Family	$0	$75	$75
• Waived for Preventive	N/A	No	No
• Annual Plan Maximum	N/A	$2,000	$2,000
• Lifetime Orthodontia Plan Maximum	N/A	$2,000	$2,000
Diagnostic and Preventive Services			
• Diagnostic and Preventive	$0 – $45 copay	100%	100%
• Oral Exams	100% covered	100%	100%
• Bitewing X-rays	100% covered	100%	100%
• Full Mouth X-rays	100% covered every 24 months	100%	100%
• Cleaning and Scaling	100% covered every six months	100%	100%
• Prophylaxis Treatments	100% covered every six months	100%	100%
• Fluoride Treatments	100% covered	100%	100%
• Space Maintainers	$10 copay	100%	100%
• Sealants	$5 copay; limited to permanent molars through age 15	100%	100%
Basic Services			$0
• Basic	$0 – $220 copay	100%	80%
• Oral Surgery *(Extractions and Other Surgical Procedures)*	$0 – $90 copay	100%	80%
• Endodontic Treatment	$0 – $220 copay	100%	80%
• Periodontic Treatment	$0 – $195 copay	100%	80%
• Re-linings and Re-basings of Existing Removable Dentures	$0 – $35 copay	100%	80%
• Repair or Re-cementing of Crowns, Inlays, Onlays, Dentures or Bridgework	$0 – $75 copay	100%	80%

For more information on Delta Dental please visit deltadentalins.com.

To look up a dental provider please visit deltadental.com/DentistSearch/DentistSearchController.ccl.

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Dental (continued)

Plan Benefits	DeltaCare USA	Delta Dental PPO	
		In-Network	Out-of-Network
Major Services			
• Major	$0 – $195 copay	60%	60%
• Crowns, Jackets and Cast Restorations	$0 – $195 copay	60%	60%
• TMJ	Not covered	Not covered	Not covered
• Prosthodontic Benefits *(Fixed Bridges, Partial/Complete Dentures)*	$0 – $195 copay	60%	60%
• Implants	Covered	60%	60%
Orthodontia Services			
• Orthodontia	$0 – $2,000 copay; see plan document for limitations	50%	50%
• Dependent Children	Covered; $0 – $2,000 copay for children up to age 19	Covered	Covered
• Adults *(and Covered Full-time Students, if eligible)*	Covered; $0 – $2,000 copay for adults and dependent adult children over age 19	Covered	Covered
• Adult Lifetime Maximum	N/A	$2,000	$2,000

For more information on Delta Dental please visit deltadentalins.com.

To look up a dental provider please visit deltadental.com/DentistSearch/DentistSearchController.ccl.

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Vision

The City offers a vision plan through VSP. The plan pays 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 non-sworn full-time and permanent part-time employees and their eligible dependents. If you use VSP providers, your costs for most services and materials are limited to the applicable copays. To find more information on VSP or to locate a provider, please visit vsp.com.

Plan Benefits	Vision Service Plan	
	In-Network	Out-of-Network
General Plan Information		
• Exam	$10 copay, combined with materials copay	Up to $50 allowance
• Materials	$10 copay, combined with materials copay	Up to $70 allowance
Benefit Frequency		
• Exam	12 months	12 months
• Lenses	12 months	12 months
• Frames	12 months	12 months
• Contacts	12 months	12 months
Covered Services		
• Single Vision Lens	Covered after copay	Up to $50
• Bifocal Lens	Covered after copay	Up to $75
• Trifocal Lenses	Covered after copay	Up to $100
• Lenticular	Covered after copay	Up to $125
• Basic Progressive	$50 copay	Up to $75
Lens Options		
• UV Coating	$14 copay	Not covered
• Tint *(Solid and Gradient)*	100%	Up to $5
• Scratch Resistance	$15 copay	Not covered
• Basic Polycarbonate	$23 copay for single vision $28 copay for multifocal	Not covered
• Standard Anti-Reflective	$37 copay	Not covered
• Other Add-Ons and Services	Discounts available	Not covered
Contact Lenses		
• Medically Necessary	Covered after copay	Up to $210 allowance
• Elective	Up to $105 allowance	Up to $105 allowance
• Frames	Up to $105 allowance	Up to $70 allowance
Other Services		
• Corrective Vision Services *(Laser Surgery)*	Discount available	Not covered
• Second Pair of Glasses	Discount available	Not covered

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Group Life and AD&D/Supplemental Life

Basic Life

The City of Oakland provides Group Life and Accidental Death and Dismemberment Insurance for full-time and permanent part-time employees through The Hartford. This benefit is fully paid for by the City of Oakland. Eligible employees are all non-sworn full-time, permanent part-time, and limited duration employees in a covered class who work at least 975 hours per year for the City on a regular basis.

- **The policy value for all eligible non-sworn full-time employees:** 100% of the person's annual earnings, (rounded to the next highest $1,000 of benefit) to a maximum of $200,000.
- **The policy value for all eligible permanent part-time employees:** An amount equal to 50% of what the person's annual earnings would be if the person worked full time (rounded to the next highest $1,000 of benefit) to a maximum of $100,000.
- **Temporary Part-time SEIU Local 1021 unit members:** The City provides a three-thousand dollar ($3,000) death benefit for each such unit member.

Don't Forget to Name a Beneficiary

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

Supplemental Life

Supplemental life insurance is available only for non-sworn full-time and permanent part-time employees and their eligible dependents. Employees can purchase supplemental life insurance in increments of $25,000 to a maximum of $500,000. If an employee enrolls when they are newly eligible or during an annual enrollment period, a Guaranteed Issue amount up to $100,000 is available without Evidence of Insurability (health questions).

The employee may also purchase coverage for their Spouse in the amount of $20,000 and for dependent children up to age 26 in the amount of $15,000.

Supplemental life insurance is fully paid for by the employee through monthly payroll deductions.

Disability

Short Term Disability (STD) and SDI

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 Oakland.

The City provides two plans: State Disability Insurance (SDI) - SEIU Local 1021 and International Brotherhood of Electrical Workers (IBEW) Local 1245 represented employees, or The Hartford - IFPTE Local 21, CMEA & Unrepresented employees. Plan eligibility is based upon your represented unit.

Long Term Disability (LTD)

The City of Oakland offers LTD benefits through The Hartford. This coverage is available for regular full-time employees and permanent part-time employees who works at least 18.50 hours per week on a regularly scheduled basis for IFTPE Local 21, CMEA & Unrepresented employees. For eligible employees, this benefit is offered at no cost. Employees are able to receive the lesser of 60% of their basic monthly earnings to a maximum of $4,500 per month.

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Other Benefits

Employee Assistance Program (EAP)

This program is offered by the City of Oakland to help employees and their families cope with difficult personal issues. The Employee Assistance Program (EAP) has counselors on staff, as well as referrals to outside resources. It is offered off-site and is strictly confidential.

Why this Service?

Personal concerns can impact your work performance and overall functioning. The EAP helps you resolve personal issues before they become more serious and difficult to manage.

Who provides the EAP?

Claremont is a firm of select professionals who can help you with life's challenges. You will be referred to a conveniently located counselor or resource with expertise in your area of concern.

Counseling Visits

The EAP offers free short-term counseling visits for almost any personal issue. Claremont will work with you to find the most appropriate counselor to meet your needs.

- Marital/relationship issues
- Parenting/family issues
- Work concerns
- Depression
- Anxiety
- Stress
- Substance abuse
- Other issue impacting your quality of life

Work/Life Referrals

Work/Life consultants can provide you with referrals and information for services such as:

- Child care
- Elder care
- Pet care
- Adoption assistance
- School/college assistance
- Health and wellness
- Convenience referrals

Legal Consultation

Attorneys are available to answer your legal questions, either in-person or over the phone. Up to 30 minutes of free consultation per incident is provided. On-going services, if required, are offered at a discount. The EAP can assist with legal issues such as:

- Divorce
- Child custody
- Real estate
- Personal injury
- Criminal law
- Free sample will kits

Financial Consultation

The EAP offers telephonic consultation on a variety of important financial issues, including:

- Budgeting
- Debt management
- Financial planning
- First time home buyer program
- Tax questions
- Identity fraud service
- Free credit report/review

For more information, please call 800-834-3733 or visit claremonteap.com.

Other Benefits (continued)

Flexible Spending Accounts (FSA)

The City offers a tax-free benefit plan that provides you with ways to save up to thousands of dollars per year by offering the option to pay for certain types of expenses with pre-tax payroll deductions. If you choose to participate, you will reduce your taxable income. FSA participants pay a monthly administrative fee of $4.40, which is paid through monthly payroll deductions. The City pays the administrative fee for IFPTE Local 21 and CMEA participating employees.

Health Care FSA

What is the maximum I can elect?

For 2026, the maximum contribution amount is $3,400.

How do I use the Medical FSA?

The Medical Expense FSA allows you to set aside tax-free dollars that will reimburse you for qualifying medical, dental and vision expenses incurred during the plan year. Incurred means the service must be performed during the plan year. Qualified expenses include most medically necessary out-of-pocket medical, dental, and vision related expenses. Insurance premiums of any kind including, Medicare, individual health insurance, long-term care, warranties, or membership fees that are not directly related to care are not eligible for reimbursement through the Medical FSA.

Can I be reimbursed through FSA for medical expenses incurred by my family members?

Yes! You may save taxes on all qualified medical expenses incurred by you, your spouse, and your dependent children. You may NOT be reimbursed for expenses incurred by a domestic partner unless your domestic partner is your federal tax dependent.

You plan allows reimbursement for qualified expenses that you incur for an eligible adult child up to the age 26.

Dependent Care Assistance Program

This option enables you to decrease your tax liability while setting aside funds to pay for child or elder care expenses. After expenses are incurred, you can submit receipts for reimbursement from a flexible spending account. The maximum annual contribution is $7,500 for a family or $3,750 each for you and your spouse.

How do I access my benefits?

Accessing your benefits couldn't be easier, just swipe your Navia Benefit Card to pay for eligible health care expenses. Funds come directly out of your Health FSA and are paid to the provider. Some swipes require us to verify the expense, so hang on to your receipts. If we need to see it, we will send you an email or notification via our smartphone app.

You can also submit Health Care FSA and Day Care FSA claims online, through our smartphone app for Android and iPhone, email, fax or mail. Claims are processed within a few days and reimbursements are issued according to your employer's reimbursement schedule. Be sure to include documentation that clearly shows the date, type and cost of the service.

Submitting claims is easier than ever using FlexConnect

The FlexConnect feature connects your FSA to your insurance plans and seamlessly creates a claim with proper documentation direct from your insurance carrier. All you have to do is click "reimburse me" and the claim is expedited for payment. Sign up for FlexConnect today.

Get more with the MyNavia mobile app

The MyNavia app is free to download on both iPhone and Android. You can manage your benefits and view important details right from the convenience of your phone.

The medical FSA account is pre-funded, meaning your entire annual election amount is available for reimbursement at any time during the plan year, regardless of the amount you have contributed from your paycheck.

Election and Claim Filing Period

Open Enrollment period is a great time to look at your benefits and estimate your out-of-pocket expenses. Be sure to only elect an amount that you know you will use during your plan year. At the end of the plan year you will have a claim fling period to turn in any leftover claims for your benefits. Money left in the plan after the end of the claim filing period and 2 ½ month Grace Period is subject to the Use-or-Lose rule and cannot be refunded to you.

Grace Period

Your plan also has a special 2 ½ month Grace Period after the end of the plan year. This feature gives you an additional 2 ½ months to incur expenses against your Health Care and Day Care arrangements. All expenses incurred during the grace period will automatically deduct out of the prior year's arrangement, and any remaining balance will then be applied to the current plan year.

Other Benefits (continued)

Navia Benefits Card

Rather than filing a claim and waiting for reimbursement, you can use the debit card to pay your provider directly for qualified health care expenses. The card is accepted at participating merchants using the Inventory Information Approval System (IIAS) and at medical care merchants using the Master-Card® system. Be sure to hang on to your receipts in case we need to see them to verify the expense eligibility. If we need to see a receipt, you will notice an alert on your mobile app and we will send you an email reminder.

Accessing Your Benefits

Navia wants to make accessing your benefits as simple and efficient as possible.

- **Online Account Access:** Order additional debit cards, update bank and address information and see up to date details of your benefits.
- **Online Claims Submission:** Upload your documentation, complete the online wizard, and voila! A reimbursement will be on its way within a few days.
- **Mobile App:** MyNavia allows you to simply snap a photo and submit for reimbursement direct from your mobile device.
- **Flexconnect:** Sync your various medical, dental and vision benefits with your FSA plan for a quick and easy reimbursement. No need to submit documentation, we'll get it from the insurance carrier.

How do I enroll in the FSA plan?

You will make your Flexible Spending Account election during Open Enrollment each year. You can obtain copies of enrollment information and instructions from the City.

The following is a sample of permitted expenses:

- Acupuncture
- Allergy treatments
- Chiropractic
- Contact lenses & supplies
- Dental (non-cosmetic)
- Doctor office visits & exams
- Glasses (prescription)
- Hearing aids
- Insulin & insulin supplies
- Insurance copays and deductibles
- Laboratory fees
- Therapy
- Psychiatric care
- Prescriptions (medically necessary)

Transit/Parking Commuter Benefits Program

Commuting to work each day can be expensive. The commuter benefit program offered by the City of Oakland through Navia will help you save money on your commuting costs. The GoNavia Program allows you to pay for work related transportation costs with pre-tax dollars.

This is a month to month benefit; employees may opt in and out or change commuter benefit election amounts from month to month, based on their transit and parking needs.

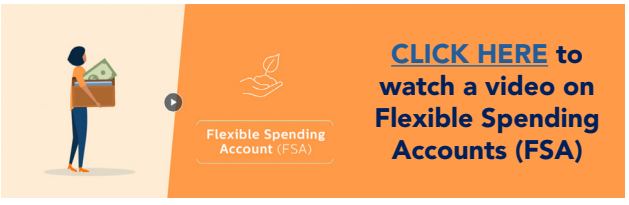
What is the maximum monthly pre-tax benefit permitted allowed?

- The maximum amount that the City of Oakland will deduct from your pay each month is equal to the maximum tax-free limit authorized by the IRS for that year.
- For 2026 the pre-tax parking limit is $340 per month.
- For 2026, the pre-tax transit and van pooling limit is $340 per month.

There is a monthly commuter benefit program administrative fee of $4.00. The City pays the administrative fee for participating IFTPE Local 21, CMEA. SEIU Local 1021, and unrepresented employees. All other participants pay the monthly administrative fee through payroll deductions.

The City of Oakland is committed to preserving the environment and wants to encourage employees to contribute to these efforts by taking public transportation whenever practical. Together we can save money and the environment at the same time!

For information about how to enroll in the Commuter Benefit online, please visit the HR department for an online instruction guide.



Other Benefits (continued)

Deferred Compensation

Full-time and permanent employees can elect to participant in the voluntary retirement plan, a 457(b), this reduces the employee's taxable income while providing savings for retirement. An employee can contribute as little as $10 per pay period up to the maximum IRS allowable limit per plan year. The City does not contribute or match the employee's contribution.

Our 457 plan also allows you to add Roth assets now for tax-free income later. Is the Roth right for you? It's a trade-off. You don't get an up-front tax benefit for Roth contributions like you do with pre-tax contributions. And converting pre-tax assets to Roth requires that you pay up-front taxes. But in exchange, Roth assets can provide tax-free income in retirement.

Retirement

In lieu of Social Security, the City of Oakland pays into the California Public Employees' Retirement System (PERS). All full-time and permanent part-time employees must make retirement contributions through bi-weekly deductions. **Rates of contributions are based on the employees' represented unit.**

- Retirement benefit amounts are calculated using the employee's service credit, benefit factor and final compensation. The current retirement formulas for non-sworn (miscellaneous) employees are:
  - **Tier One (Classic Members):** Classic Formula 2.7 @ age 55; final compensation will be based on any 12 highest consecutive months.
  - **Tier Two (new City of Oakland hires as of June 8, 2012):** Classic Formula 2.5% @ age 55; final compensation will be based on the average of three consecutive years prior to retirement date.
  - **Tier Three (new hires as of January 1, 2013):** New Formula 2% @ age 62; final compensation will be based on the average of three consecutive years prior to retirement date.
- An employee becomes vested in retirement system after five years of service.
- Employees in Tier One and Tier Two are eligible to retire as early as age 50. Employees in Tier Three are eligible to retire at age 52. Early retirement is subject to proration of retirement rates stated above.
- The required employee contribution towards retirement for Tier One and Tier Two employees is 8% of base salary. Tier Three employees have a 8.25% contribution rate. This amount is deducted from your paycheck. The funds paid by the employee go into an account and earn interest. If you separate from employment for reasons other than retirement, you are entitled to withdraw these funds of if vested, leave them in the account and defer retirement.
- Employees who have service credit with other CalPERS agencies or have service in a reciprocal member agency will receive retirement benefits for those years based on the respective agency's retirement formula and final compensation.
- Retirees may receive a cost of living adjustment up to 2% per year.
- Employees retiring from the City of Oakland are entitled to automatically continue their medical coverage with CalPERS. Non-sworn employees who have at least 10 years of service with the City of Oakland may be eligible to have their medical subsidized by the City. This benefit is subject to the employee's Memorandum of Understanding (MOU).
- Employees interested in learning more about their retirement may contact CalPERS directly at 888-225-7377 or visit the CalPERS website at calpers.ca.gov. Alternatively, employees may also contact the City of Oakland's Retirement Office at 510-238-6479 or 510-238-6480, weekdays from 8:30 AM to 5:00 PM.

Unemployment Insurance

This benefit, which is offered through the State of California's Employment Development Department (EDD), allows you to receive funds in the event you become unemployed.

Other Benefits (continued)

Guaranteed Ride Home (GRH)

The Alameda County Guaranteed Ride Home (GRH) Program provides a free ride home from work for employees who do not drive alone to work when unexpected circumstances arise. The GRH program is free for employees who work in Alameda County and use sustainable forms of transportation including walking, biking, taking transit or ridesharing. When a registered employee uses a sustainable mode to travel to work and experiences a personal or family emergency while at work, they can take a taxi or rental car ride home and be reimbursed for the cost of the ride.

This program allows commuters to feel comfortable taking the bus, train or ferry, carpooling, vanpooling, walking, or bicycling to work, knowing that they will have a ride home in case of an emergency.

All permanent part-time or full-time employees 18 years of age or older who work in Alameda County are eligible to participate.

When can I take a Guaranteed ride home?

Registered employees may request reimbursement for eligible expenses if they take a trip home in a qualified emergency situation and have used an alternative mode that day.

The following circumstances are considered qualifying emergency situations in the GRH program and must occur on the date of the GRH trip:

- Participant or an immediate family member suffers an illness, injury, or severe crisis.
- Participant is asked by supervisor to work unscheduled overtime. Supervisor verification will be required as part of reimbursement request.
- Participant ridesharing vehicle breaks down or the driver has to leave early.
- Participant has a break-in, flood, or fire at residence.
- Participant's commute bicycle breaks down on the way to or from work and cannot be repaired at participant's work site.

In addition, participants must have used an alternative mode on the day they take the ride for which they will seek reimbursement through the GRH program. Eligible alternative commute modes include:

- **Public transportation including:** BART, AC Transit, ACE, Wheels, Union City Transit, ferry (WETA) and Amtrak
- Employer-provided shuttle or van service
- Carpool or Vanpool
- Bicycle
- Walk
- Uber
- Lyft

Enrollment can be completed online at grh.alamedactc.org. For questions, please contact Guaranteed Ride Home (GRH) at 510-433-0320 or ridehome@alamedactc.org.

The Club At City Center

City of Oakland employees are eligible to receive a discount with The Club At City Center.

- **Single Site Only –** Oakland No other participating gyms
- $90 Per Month (EE)
- $180 Per month (EE + 1 add on - must be 18+)
- $25 One-Time Registration Fee (for new members)
- Waived for existing members.

Initial enrollment requires payment of 1st and last month dues in addition to a one-time registration fee for new members. 30 day cancellation notice required.

You must pay membership dues via a post-tax payroll deduction in-order to receive the City discount.

To request enrollment, please visit the City of Oakland website to access the Payroll Deduction Authorization form.

Deduction Schedules

Deduction Frequency by Benefit		
Program	**Deduction Frequency**	**Deduction Period**
Medical	Monthly	1st PPE
Dental *(PPT Employees Only)*	Monthly	1st PPE
Vision *(PPT Employees Only)*	Monthly	1st PPE
Transit / Parking	Monthly	2nd PPE
Flexible Spending	Bi-weekly	Every PPE
Deferred Compensation	Bi-weekly	Every PPE
Supplemental Life Insurance	Monthly	2nd PPE
Gym Dues	Monthly	2nd PPE

Medical, Dental, Vision Election Schedule – 2026			
Benefit Month	**Submission Deadline**	**Coverage Effective Date**	**Deduction Date (Pre-Tax Payroll)**
Dec 2025	Dec 31, 2025	Jan 1, 2026	Jan 8, 2026
Jan 2026	Jan 31, 2026	Feb 1, 2026	Feb 19, 2026
Feb 2026	February 29, 2026	Mar 1, 2026	Mar 19, 2026
Mar 2026	Mar 31, 2026	Apr 1, 2026	Apr 16, 2026
Apr 2026	Apr 30, 2026	May 1, 2026	May 14, 2026
May 2026	May 31, 2026	Jun 1, 2026	Jun 11, 2026
Jun 2026	Jun 30, 2026	Jul 1, 2026	Jul 9, 2026
Jul 2026	Jul 31, 2026	Aug 1, 2026	Aug 20, 2026
Aug 2026	Aug 31, 2026	Sep 1, 2026	Sep 17, 2026
Sep 2026	Sep 30, 2026	Oct 1, 2026	Oct 15, 2026
Oct 2026	Oct 31, 2026	Nov 1, 2026	Nov 12, 2026
Nov 2026	Nov 30, 2026	Dec 1, 2026	Dec 10, 2026
Dec 2026	Dec 31, 2026	Jan 1, 2027	Jan 7, 2027

Transit Program Election & Deduction Schedule – 2026		
Election Deadline	**Benefit Month**	**Deduction Date**
Dec 20, 2025	Jan 2026	Thursday, January 15, 2026
Jan 20, 2026	Feb 2026	Friday, February 15, 2026
Feb 20, 2026	Mar 2026	Friday, March 15, 2026
Mar 20, 2026	Apr 2026	Monday, April 15, 2026
Apr 20, 2026	May 2026	Wednesday, May 15, 2026
May 20, 2026	Jun 2026	Friday, June 14, 2026
Jun 20, 2026	Jul 2026	Monday, July 15, 2026
Jul 20, 2026	Aug 2026	Thursday, August 15, 2026
Aug 20, 2026	Sep 2026	Friday, September 13, 2026
Sep 20, 2026	Oct 2026	Tuesday, October 15, 2026
Oct 20, 2026	Nov 2026	Friday, November 15, 2026
Nov 20, 2026	Dec 2026	Friday, December 13, 2026

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

The City of Oakland 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). The City of Oakland 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 a 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 (510) 238-7446.

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, please contact your carrier.

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, please contact your carrier.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with CalPERS. 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.

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 receive 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 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 the 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.

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 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 eight-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.

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.

[1] http://www.socialsecurity.gov/

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.

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 a 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:

Denise Carter
Human Resources
(510) 238-7446

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

City of Oakland Group 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 Human Resources.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about City of Oakland 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 begins on November 1 of each year and ends on January 31 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com, 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 9.96% (for 2026) 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.

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 Oakland	**4. Employer Identification Number (EIN)** 94-6000384	
5. Employer address 150 Frank Ogawa Plaza, 3rd Floor	**6. Employer phone number** (510) 238-7446	
7. City Oakland	**8. State** CA	**9. ZIP code** 94612
10. Who can we contact about employee health coverage at this job? Denise Carter, Human Resources		
11. Phone number (if different from above)	**12. Email address** dcarter@oaklandca.com	

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.

Notice of Creditable Coverage: Information About Medicare Part D and Your Prescription Drug Coverage

The City of Oakland has determined that the prescription drug coverage offered by the CalPERS plan is, on average for all plan participants, expected to pay out same or more than what the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Please read this notice carefully and keep it where you can find it. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. NOTE: You are responsible for providing this notice to all Medicare eligible family members (or those about to become Medicare eligible).

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

When someone first becomes eligible to enroll in a government-sponsored Medicare "Part D" prescription drug plan, enrollment is considered timely if completed by the end of his or her "Initial Enrollment Period" which ends three months after the month in which he or she turned 65.

Unfortunately, if you choose not to enroll in Medicare Part D during your Initial Enrollment Period, when you finally do enroll, you may be subject to a late enrollment penalty added to your monthly Medicare Part D premium. Specifically, the extra cost, if any, increases based on the number of full, uncovered months during which you went without either Medicare Part D or without "Creditable" prescription drug coverage from another plan, such as our plan.

Eligible individuals can enroll in a Medicare Part D prescription drug plan during Medicare's "Annual Coordinated Election Period" (a.k.a. "Open Enrollment Period") running from October 15 through December 7 of each year, as well as during what is known as a "Medicare Special Enrollment Period" which is triggered by certain qualifying events, including the loss of creditable group prescription drug coverage. Those who miss these opportunities are generally unable to enroll in a Medicare Part D plan until another enrollment period becomes available. Finally, please be cautioned that even if you elect our coverage, you could be subject to a payment of higher Part D premiums if you subsequently experience a break in coverage of 63 continuous days or longer before you enroll in the Medicare Part D plan. Carefully coordinating your transition between plans is therefore essential.

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 Oakland coverage will not be affected. If you keep this coverage and elect Medicare, the current City of Oakland coverage will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current CalPERS coverage, be aware that you and your dependents may be unable to get this coverage back.

It is important for those eligible for both Medicare and our group health plan to look ahead and weigh the costs and benefits of the various options on a regular, if not annual, basis. Based on individual facts and circumstances, some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, please note that benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would reduce their payment to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

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

If you are Medicare eligible and 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 creditable coverage. For example, if you go 19 months without creditable coverage, your premium may be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) the entire time you have Medicare prescription drug coverage.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

If you have questions about your Medicare eligibility or how you can get help to pay for it, you can call the Social Security Administration at 1-800-772-1213 or visit www.socialsecurity.gov.

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, dial 1-877-KIDS-NOW, or visit www.insurekidsnow.gov to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

If you live in one of the following States, you may be eligible for assistance with paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility.

ALABAMA - Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA - Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS - Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (1-855-692-7447)

CALIFORNIA - Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 1-916-445-8322
Fax: 1-916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/chp
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA - Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

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

INDIANA - Medicaid
Website: https://www.in.gov/medicaid/ or
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid & CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program
HIPP Phone: 1-888-346-9562

Important Notices (continued)

KANSAS - Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPAA Phone: 1-800-967-4660

KENTUCKY - Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://www.chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.Program@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA - Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE - Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS - Medicaid & CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA - Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI - Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA - Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA - Medicaid
Website: http://www.accessnebraska.ne.gov/
Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178

NEVADA - Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 1-603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY - Medicaid & CHIP
Medicaid Website:
https://www.nj.gov/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 1-609-631-2392
CHIP Website: https://njfamilycare.dhs.state.nj.us/
CHIP Phone: 1-800-701-0710 (TTY 711)

NEW YORK - Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA - Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 1-919-855-4100

NORTH DAKOTA - Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP
Website: http://www.insureoklahoma.org/
Phone: 1-888-365-3742

OREGON - Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid & CHIP
Website: https://www.pa.gov/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND - Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA - Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

Important Notices (continued)

TEXAS - Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH - Medicaid & CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website:
https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website:
https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT - Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA - Medicaid & CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON - Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA - Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 1-304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid & CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING - Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

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.