At the City of Anaheim, we're committed to offering a variety of benefits to meet your diverse needs.

The City’s benefits program is just one way we reward you for your hard work and dedication. Click the links above to find out more about your benefit options.

If you have any questions, contact the Human Resources Department at 714-765-5185.
Get Informed

Use this section to learn all about your City of Anaheim benefits. Here, you can learn more about your: medical plan options, dental plan options, vision coverage, and other city benefits by using the navigation at the left.

Use this as a resource for information year-round, and to help you make informed decisions during our Open Enrollment period, held each fall.

Take a look around this interactive guide to learn more about the City’s benefits program. Remember, the underlined text throughout this guide will also link to more information.
Medical Plan Options

The following pages contain brief descriptions of how each plan works. Refer to the 2017 Employee Benefits Summary Comparison Chart for more information about what you pay for key services. Keep in mind that each plan has special rules regarding coverage outside the service area. Call your plan for information before you travel.

The medical plan options available to you are based on where you live.

<table>
<thead>
<tr>
<th>If You Live:</th>
<th>These Plans Are Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>In California and within the HMO network areas</td>
<td>X            Aetna          Aetna OAMC</td>
</tr>
<tr>
<td>In California and outside the HMO network areas</td>
<td>X            X             Aetna OAMC</td>
</tr>
<tr>
<td>Outside California</td>
<td>X            X             X</td>
</tr>
</tbody>
</table>

When considering your medical plan options, it’s important to compare the contributions you’ll pay for coverage. Please refer to the 2017 Rate Sheet for more information on what your contributions will be under each plan.

In addition to contributions, you’ll want to consider the level of benefits you’ll receive and:

- **Your lifestyle:** Do you travel a lot or have a residence in another area or state? Are preventive services important to you?

- **Health care providers:** Is it important for you to continue seeing a doctor who may not be in one of the HMO networks? Are the doctors and hospitals convenient? Does your current provider participate in another plan’s network that has lower contributions?

- **Cost:** Cost differences among plans may be small or significant. Consider the differences in services, conveniences, etc., and determine what is best for you.
Aetna Open Access Managed Choice Plans

The Aetna Open Access Managed Choice (OAMC) plans give you the freedom to receive all covered services from the physician of your choice. The City offers two OAMC plans:

- The Aetna OAMC plan
- The Aetna HSA OAMC plan.

The plans are similar in some ways, but operate very differently.

Learn [How The Plans Are Alike](#)

Find out [How The Plans Are Different](#)

**PLAN ADMINISTRATION**

Learn more about Aetna's Coordination of Benefits and Preauthorization processes. Click the links below.

- Coordination of Benefits
- Preauthorization

Refer to the [2017 Employee Benefits Summary Comparison Chart](#) for a summary of benefits under the Aetna OAMC plans.
### How The Aetna OAMC Plans Are Alike

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Aetna OAMC Plan and Aetna HSA OAMC Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td>Both plans cover in-network preventive care at 100% with no deductible required.</td>
</tr>
<tr>
<td>Provider Network</td>
<td>Both plans use the same Aetna OAMC provider network.</td>
</tr>
</tbody>
</table>
| Provider Reimbursement       | • You do not have to choose a primary care physician.  
|                              | • If you choose an in-network provider, covered services are paid at a higher percentage of a pre-negotiated rate.  
|                              | • When you choose an out-of-network provider you have higher out-of-pocket costs because the plan pays a lower percentage of reasonable and customary charges for most services; you must pay the full amount over reasonable and customary charges. |
| Prescription Drugs           | You pay a copay for prescription drugs with no deductible required. |

### Get Help When You Need It Most

Aetna OAMC plan participants can access Aetna’s In Touch Care program for added help when facing an acute or chronic health care situation. You’ll be paired with a nurse who will help you navigate the health care system, coordinate your care, answer your questions, and help you manage your condition to stay as healthy as possible. And, you can access online tools and programs that offer assistance 24/7. To enroll in In Touch Care, log in to your secure member website and click on Health Programs.
How The Aetna OAMC Plans Are Different
The two Aetna plans have some significant differences in how they work, highlighted below.

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Aetna OAMC Plan</th>
<th>Aetna HSA OAMC Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Your Cost for Contributions</strong></td>
<td>Higher than the HSA plan</td>
<td>Lower than the OAMC Plan</td>
</tr>
<tr>
<td><strong>Calendar-Year Deductible</strong></td>
<td>When you choose in-network providers, you pay a copay, with no deductible required, for: • Office and specialist visits • Prescription drugs For most other medical care, except preventive care, you must meet the deductible before the plan pays benefits.</td>
<td>You have to pay the full cost of all medical care and prescription drugs until you meet the deductible. For employees who cover dependents, there is an individual limit applied to the deductible. When an individual’s expenses meet the limit, that individual will pay coinsurance for care. All other family members must continue to pay the full costs until the remaining family deductible is met.</td>
</tr>
<tr>
<td><strong>Paying Your Share</strong></td>
<td><strong>In-network</strong>: You pay copays with no deductible required. <strong>Out-of-network</strong>: You pay coinsurance with no deductible required. In-network and out-of-network pharmacies are covered.</td>
<td><strong>In-network and out-of-network</strong>: You pay coinsurance after you meet the deductible. Coinsurance for in-network is lower than for out-of-network. Only in-network pharmacies are covered; there is no out-of-network coverage.</td>
</tr>
</tbody>
</table>
### Medical Plan Options

- **Aetna Open Access Managed Choice Plans**
- Health Maintenance Organizations (HMOs)
- Prescription Drug Coverage
- Medical Plans at a Glance

### Dental Plan Options

- Vision Coverage
- Other City Benefits

### How The Aetna OAMC Plans Are Different (continued)

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Aetna OAMC Plan</th>
<th>Aetna HSA OAMC Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>For those with dependent coverage, once an individual meets the individual out-of-pocket maximum, the plan will pay 100% of that person's eligible expenses for the rest of the year. Once the family out-of-pocket maximum is met, the plan will pay 100% of eligible expenses for the whole family for the rest of the year.</td>
<td>For those with dependent coverage, there is an individual out-of-pocket maximum limit. Once an individual reaches that limit, the plan pays 100% for that person’s eligible expenses for the rest of the year. All other family members will continue to pay coinsurance until the family maximum is reached. After that, the plan will pay 100% of eligible expenses for the whole family for the rest of the year.</td>
</tr>
<tr>
<td><strong>Tax-Saving Health Expense Account</strong></td>
<td>You may make pre-tax contributions to a Health Care FSA for expenses during the current plan year only. Money remaining at the end of the year is forfeited.</td>
<td>You may make pre-tax contributions to a Health Savings Account for expenses during the current plan year or future plan years. Money remaining at the end of the year will roll over into next year.</td>
</tr>
</tbody>
</table>
### How the Aetna HSA OAMC Plan Works

The chart below provides an overview of how the Aetna HSA OAMC Plan works.

<table>
<thead>
<tr>
<th><strong>Preventive Care – FREE</strong></th>
<th>1. Preventive care is the HSA plan’s foundation and it provides you with important information to help you improve and maintain your health with an eye toward keeping your health care costs lower. When you use in-network providers, it’s covered at 100% with no deductible!</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar-Year Deductible</strong></td>
<td>2. You must meet the deductible. You must pay the full cost of care and prescription drugs until the calendar-year deductible is met. If you cover dependents, when any one person meets the individual limit, that person will begin to pay coinsurance for care and copays for drugs. All other family members will continue paying the full cost until the remaining family deductible is met. You can use HSA funds to help pay for expenses that count toward meeting your deductible.</td>
</tr>
<tr>
<td><strong>Coinsurance</strong></td>
<td>3. You and the plan share the costs. After you meet the deductible, the plan pays a percentage of the cost for your eligible services, and you pay the rest. For prescription drugs, you’ll pay a copay and the plan will pay the rest. You can use funds in your HSA to pay for your coinsurance.</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>4. The plan’s out-of-pocket maximum caps the expenses you will have to pay during the year. After your expenses reach the out-of-pocket maximum, the plan pays 100% of your eligible expenses for the rest of the year. If you cover dependents, when one individual meets the individual limit, the plan will pay 100% of that person’s eligible expenses for the rest of the year. All other family members will continue paying coinsurance until the remaining family out-of-pocket maximum met.</td>
</tr>
</tbody>
</table>

---

**Don’t forget to open your HSA!**

If you enroll in the Aetna HSA OAMC plan, you can open a Health Savings Account (HSA) through PayFlex. This is a special account that lets you use tax-free dollars to pay for expenses like deductibles and coinsurance either now or in the future. At the City, an HSA is available only to those enrolled in the Aetna HSA OAMC plan. Check out the [Health Savings Account](#) section for more information.
Health Savings Account (HSA)

If you enroll in the Aetna HSA OAMC medical plan, you may be eligible to open a Health Savings Account (HSA). You can make pre-tax payroll contributions and after-tax contributions directly into your account, up to the maximum contribution allowed by the IRS.

You can use your HSA balance to pay for eligible health care expenses with tax-free dollars. In addition, there are some features that are unique to HSAs:

- Any unused money at the end of the year will roll over into next year, so your account balance can grow over the years.
- Once your account balances reaches $1,000, you can invest your HSA funds.
- You own your HSA balance. So, if you should leave the City you can take your HSA with you.
- To contribute funds in your HSA, you must be enrolled in a plan like the Aetna HSA OAMC plan, called a high deductible health plan.

You can sign up for your HSA when you enroll in the Aetna HSA OAMC plan. You’ll receive a welcome kit from the HSA administrator, PayFlex, which includes instructions about how to open your account, as well as more information about using your account. Once you open your account, your contributions will be credited to it and you can begin using it to pay for eligible expenses for you and your dependents (excluding domestic partners).
If you enroll for your HSA through PayFlex, you can make pre-tax contributions directly from your paycheck. You can also make after-tax contributions directly into your account. Each year, you may contribute up to the maximum amount allowed by the IRS. For 2017, the maximum contribution allowed is:

- $3,400 if you have individual coverage, or
- $6,750 if you cover yourself and one or more dependents.
- If you are age 55 or older, you may make an additional catch-up contribution of up to $1,000.

You can use your HSA balance to pay for qualified health care expenses, such as deductibles, coinsurance or copays, and other out-of-pocket health care expenses. Any money you don't use this year will automatically roll over into your HSA for next year. You can use HSA funds to pay for eligible expenses at any time, as long as you are enrolled in a high deductible health plan, like the Aetna HSA OAMC plan.

If you enroll in the Aetna HSA OAMC Plan, you will only be eligible to participate in a Health Savings Account. You will not be eligible to enroll in a Health Care FSA.
Health Maintenance Organizations (HMOs)

The HMOs offer low-cost, efficient medical care with an emphasis on prevention. The City offers two HMO plans:

- Aetna HMO
- Kaiser HMO

You must use doctors and hospitals associated with the HMO, or you won’t receive benefits. Certain emergencies are an exception. Most eligible expenses are paid at 100% after a small copay. And, you don’t pay an annual deductible or file claim forms.

Emergency and Urgent Care

Most plans have special rules regarding emergency and urgent care. See the plan literature from your plan carrier for details.
Prescription Drug Coverage

Prescription drug coverage is automatic when you enroll in a City-sponsored medical plan. Prescription drug coverage is provided through the plan in which you’re enrolled.

**Aetna Plans**

When you fill a prescription at a network pharmacy, you can receive up to a 30-day supply of medication. To find a network pharmacy, go to [www.aetna.com](http://www.aetna.com).

When you use the mail-order program, you can save money because you’ll receive up to a 90-day supply of medication for twice the copay you’d pay for a 30-day supply at a retail pharmacy.

**Types of Drugs**

Under the Aetna plans, the amount you pay for your prescription depends on whether it’s:

- Generic
- Brand-name (formulary)
- Non-formulary.

The formulary is a list of prescription drugs approved by Aetna for coverage. If your prescription drug isn’t on the formulary list, you’ll pay the highest copay when you fill your prescription. Prescription drugs occasionally move from brand-name (formulary) to non-formulary status throughout the year. Also, new generic drugs come to market periodically. Be sure to check the formulary list regularly to make sure you receive a drug that’s the best value for you.

Note: If there’s a generic equivalent to a brand-name drug and you or your physician chooses to request the brand-name drug, you’ll be responsible for paying the difference between the cost of the brand-name drug and the generic equivalent, plus the brand-name copay.

**Kaiser HMO**

If you elect the Kaiser HMO, you can fill your prescription at any Kaiser pharmacy or you can use their mail-order program. Regardless of which option you use, you’ll pay the same copay and receive up to a 100-day supply of medication. To find a network pharmacy, go to [www.kp.org](http://www.kp.org).
# Medical Plans at a Glance

Here's an at-a-glance look at your medical plan options. You can also refer to the [2017 Employee Benefits Summary Comparison Chart](#) for more detail.

<table>
<thead>
<tr>
<th>Medical Plans at a Glance</th>
<th>Kaiser HMO</th>
<th>Aetna HMO</th>
<th>Aetna OAMC</th>
<th>Aetna HSA OAMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar-Year Deductible</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>None</td>
<td>None</td>
<td>$500</td>
<td>$2,600</td>
</tr>
<tr>
<td>Family</td>
<td>None</td>
<td>None</td>
<td>$1,000</td>
<td>$5,200</td>
</tr>
<tr>
<td>Calendar-Year Out-of-Pocket Maximum</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,500</td>
<td>$2,000</td>
<td>$2,000</td>
<td>None</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000</td>
<td>$4,000</td>
<td>$4,000</td>
<td>$13,100</td>
</tr>
<tr>
<td>Professional Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits/consultations</td>
<td>$15 copay</td>
<td>$20 copay</td>
<td>$20 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Specialist visits</td>
<td>$15 copay</td>
<td>$40 copay</td>
<td>$40 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Preventive health care*</td>
<td>None</td>
<td>None</td>
<td>$500</td>
<td>$2,600</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>$10 copay</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Brand name</td>
<td>$10 copay</td>
<td>$30 copay</td>
<td>$30 copay</td>
<td>$30 copay</td>
</tr>
<tr>
<td>Non-formulary</td>
<td>Not Covered</td>
<td>$50 copay</td>
<td>$50 copay</td>
<td>$50 copay</td>
</tr>
<tr>
<td>Mail order</td>
<td>$10 copay</td>
<td>Double the applicable copay</td>
<td>Double the applicable copay</td>
<td>Double the applicable copay</td>
</tr>
</tbody>
</table>

* Coverage for preventive health care also includes women's preventive care (e.g., coverage for specified contraceptive methods and counseling; breast-feeding support and equipment; prenatal care; gestational diabetes screening; annual well-woman exam; and annual mammogram).
Dental Plan Options

You may enroll yourself and your eligible family members in one of two available dental plans, or you may decline dental coverage. You may enroll yourself and your eligible family members for dental coverage even if you decline medical coverage, or enroll only yourself in medical coverage.

Delta Dental PPO Plan

When you or your enrolled family members need dental care, you may go to any licensed dentist. However, if you choose a dentist from the network of Delta Dental PPO providers, you pay less.

When you call your dentist to make an appointment, ask if he or she participates in the Delta Dental PPO network. Dentists who participate in Delta Dental generally charge you less for each service.

DeltaCare USA Dental Health Maintenance Organization

The DeltaCare USA dental health maintenance organization (DHMO) plan from Delta Dental works like a medical HMO. You must receive your care from a DeltaCare USA contracted dentist, there are no deductibles to pay, and preventive and most basic care is covered at 100%. Major services, such as oral surgery and periodontic treatments, may require copays. Orthodontia also is covered at a set copay for children and adults.

Check the 2017 Employee Benefits Summary Comparison Chart for amounts each plan pays.

Find a Delta Dental Dentist

You can search for a Delta Dental dentist, or find a list of participating dentists at www.deltadentalins.com.
## Dental Plans at a Glance

Here's an at-a-glance look at your dental plan options.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Delta Dental PPO Plan</th>
<th>DeltaCare USA DHMO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Calendar year deductible</td>
<td>$25</td>
<td>$50</td>
</tr>
<tr>
<td>Maximum annual benefit</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
<tr>
<td>Choice of dentist</td>
<td>Delta Dental PPO dentist</td>
<td>Any dentist</td>
</tr>
</tbody>
</table>

### Diagnostic and Preventive

<table>
<thead>
<tr>
<th>Service</th>
<th>Delta Dental PPO Plan</th>
<th>DeltaCare USA DHMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodic oral exam (2 per calendar year)</td>
<td>No charge</td>
<td>20%</td>
</tr>
<tr>
<td>Teeth cleaning (2 per calendar year)</td>
<td>No charge</td>
<td>20%</td>
</tr>
<tr>
<td>Routine X-rays</td>
<td>No charge</td>
<td>20%</td>
</tr>
</tbody>
</table>

### Restorative Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Delta Dental PPO Plan</th>
<th>DeltaCare USA DHMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amalgam filling</td>
<td>No charge</td>
<td>20%</td>
</tr>
<tr>
<td>Biopsy of oral tissue</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Extractions</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Removal of impacted teeth</td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

### Orthodontics

<table>
<thead>
<tr>
<th>Age</th>
<th>Delta Dental PPO Plan</th>
<th>DeltaCare USA DHMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult (full banded)</td>
<td>50% (subject to a $1,500 lifetime maximum benefit per person)</td>
<td>50% (subject to a $1,500 lifetime maximum benefit per person)</td>
</tr>
<tr>
<td>Child (full banded)</td>
<td>50% (subject to a $1,500 lifetime maximum benefit per person)</td>
<td>50% (subject to a $1,500 lifetime maximum benefit per person)</td>
</tr>
</tbody>
</table>

1. In-network deductible waived for diagnostic and preventive services.
2. One additional oral exam and cleaning per year is covered for pregnant women.
3. In-network and out-of-network deductibles waived for amalgam fillings.
4. Doesn't include pathology laboratory procedures.
5. $110 if there are unusual surgical complications.
7. Children to age 19.
Vision Coverage

When you enroll in any of the City-sponsored medical plans, you automatically receive vision care coverage through the plan. Refer to the 2017 Employee Benefits Summary Comparison Chart for the benefits each plan pays.

### Does Your Medical Plan Cover Out-of-Network Vision Providers?

While you’ll generally pay less when you see an in-network vision provider, some of the City’s medical plans also provide coverage for out-of-network care. Refer to the table below to see if your medical plan provides out-of-network vision coverage.

<table>
<thead>
<tr>
<th>Vision Plan</th>
<th>Does It Provide Out-of-Network Vision Coverage?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna HMO</td>
<td>No</td>
</tr>
<tr>
<td>Aetna OAMC</td>
<td>Yes, up to a $200 annual allowance for materials</td>
</tr>
<tr>
<td>Aetna HSA OAMC</td>
<td>Yes, up to a $200 annual allowance for materials</td>
</tr>
<tr>
<td>Kaiser HMO</td>
<td>No</td>
</tr>
</tbody>
</table>

**Kaiser HMO**

If you’re enrolled in the Kaiser HMO, you must receive your vision care from a provider in the plan’s network. Refer to the 2017 Employee Benefits Summary Comparison Chart before selecting a plan.
Aetna Plans

Depending on which Aetna medical plan you enroll in, you may have the following options for receiving vision care:

**In-Network**

When you use an in-network provider, you'll generally pay less, your in-network provider will take care of billing Aetna directly, and you won't have to file a claim form. Keep in mind that if you're enrolled in an Aetna HMO plan, you can receive vision care only from an in-network provider.

You have two options when it comes to using in-network providers:

1. **EyeMed Select Network**
   Aetna contracts with EyeMed to use EyeMed's national network of vision providers who participate in the Aetna Vision discount program. When you purchase eyeglasses, contacts, and other vision-related items, you won't have to submit a claim form — the EyeMed provider will coordinate the claim process. Additionally, you'll save more money on these materials when you purchase them from an EyeMed provider. To find an EyeMed provider, go to [www.aetna.com/docfind](http://www.aetna.com/docfind). For the Provider Category, choose “Vision (routine exam and eyewear)” from the drop-down menu.

2. **Providers Who Contract Directly with Aetna**
   Providers who contract directly with Aetna perform covered routine eye exams, but they don't participate in the Aetna Vision discount program. This means that if you purchase eyeglasses, contacts, and other vision-related items through an Aetna provider, you'll submit a claim form and be reimbursed up to the plan's allowance for those services. To find a provider who contracts with Aetna, go to [www.aetna.com/docfind](http://www.aetna.com/docfind).

**Out-of-Network**

Depending on the medical plan you're enrolled in, you may have the option of receiving vision care from a provider outside the Aetna network. You'll generally pay more for services when you go to an out-of-network provider, and you are responsible for paying for these costs yourself and then submitting a claim form for reimbursement.
Other City Benefits

Employee Assistance Plan Benefits

The City offers the REACH employee assistance plan (EAP) which is available free of charge to all City employees and their families. REACH provides free confidential counseling for both personal and work-related issues. REACH counselors are experienced, licensed professionals who have special training in employee assistance consultation.

For each issue you need assistance with, the City pays for up to three visits per year. This means that if you experience two separate issues during the year, the City will pay the full cost of up to six visits.

REACH can also provide referrals for community-based program resources and child and elder care resources.

Contact REACH at 800-273-5273, or visit [www.reachline.com](http://www.reachline.com).
Disability Insurance

If an illness or injury prevents you from working, the City offers two disability plans to protect your income for both short-term absences and longer periods of disability. Generally, the City provides these disability insurance plans at no additional cost to you. Contact Human Resources for more information on your disability insurance benefits.

Short-Term Disability (STD)

The first 30 days of disability (or 10 regularly scheduled work shifts for Fire Safety Employees) are covered by sick leave, vacation, or unpaid leave (if other leave time is not available). If a disability lasts longer than 30 calendar days, STD coverage will pay a certain percent of your base pay up to a maximum of 150 days. Your benefit amount depends on your employee unit of representation.

Long-Term Disability (LTD)

You're eligible for LTD after 180 days of disability. LTD benefits will pay 60% of pre-disability base pay for as long as you remain disabled or until the maximum coverage age is reached.
Life and Accident Insurance

The City offers two life and accident insurance plans to protect against financial hardship that can accompany a death or accidental injury.

Basic Life Insurance
The City provides you with the opportunity to elect Basic Life Insurance. The amount of coverage available to you depends on your employee unit of representation. You may also elect dependent life coverage for your spouse, domestic partner, or eligible dependent children.

Supplemental Life Insurance
If you feel your family needs a higher level of protection than Basic Life Insurance provides, you may purchase additional life insurance coverage for you, your spouse, domestic partner, or eligible dependent children to supplement your Basic Life Insurance. You pay the full cost of coverage. The cost of Supplemental Life Insurance depends on your age and coverage amount. Your Supplemental Life Insurance benefit is portable, so you can keep it if you change jobs.

Accidental Death & Dismemberment Insurance (AD&D)
The City provides you with Basic AD&D Insurance to protect you and your family financially in the case of an accidental death or injury. The amount of coverage available to you depends on your employee unit of representation.
Flexible Spending Accounts (FSAs)

The City of Anaheim offers two tax-saving opportunities: the Health Care FSA and the Dependent Care FSA. FSAs help you to plan for expenses you’ll incur throughout the year and to reduce the amount you pay in taxes by lowering your taxable income.

How FSAs Work

- When you enroll, you specify the dollar amount of your earnings to be deposited into each account per pay period. For ESS Enrollment instructions, see How to Enroll.
  - The amount you specify is deducted from your pay before taxes are taken out, lowering your taxable income.
  - It’s important to estimate your expenses carefully, because IRS regulations require that any unused money left in your account at the end of the grace period be forfeited. Your funds do not roll over from year to year. Generally you’re not allowed to make changes to your annual election after you enroll.
  - You’re reimbursed from the money you’ve set aside in your FSA(s). You can be reimbursed for eligible expenses you incur during 2017, or during the 2½-month grace period from January 1, 2018 – March 15, 2018.
  - You’ll receive an FSA debit card to be used at your provider just like a credit card at the time of service. The deadline for filing claims is three months after either the grace period ends (by June 15 of the following year) or you end your FSA participation. If you leave the City during the year, you can continue to file claims, but only for expenses incurred while you were actively participating in an FSA.

FSA Contribution Maximums

Each year, you can contribute up to $2,550 to your Health Care FSA and up to $5,000 to your Dependent Care FSA.

Aetna HSA OAMC Plan Participants

If you’re in the Aetna HSA OAMC medical plan and elect to contribute to a Health Savings Account (HSA), you cannot have a Health Care FSA. See Health Savings Account (HSA) for more information about this tax-free way to pay for health care expenses.
Eligible/Ineligible Expenses
Click the boxes below to see a few examples of eligible and ineligible expenses for the Health Care and Dependent Care FSAs.

Important FSA Rules to Remember
- You must use all the money you’ve set aside in the FSA for eligible expenses incurred during the calendar year and the 2½ month grace period — January 1 through March 15 of the following year — or you lose it. Be sure to estimate carefully.
- Your Health Care FSA and Dependent Care FSA are separate accounts. You can’t use money in one account to pay for expenses related to the other.
- Once you set up an FSA for the year, you can’t change your contribution amount until the next Open Enrollment. The only exception is if you have a qualifying event — for example, you get married or have a baby.
- Some health care and dependent care expenses aren’t eligible for reimbursement.
Retirement Health Savings (RHS) Plan

The Retirement Health Savings (RHS) Plan, offered through ICMA-RC, is an employer-sponsored health benefit savings vehicle that allows for the accumulation of assets to pay for certain medical expenses in retirement on a tax-free basis. Availability of this benefit is based on your unit of representation and hire date.

How the RHS Plan Works

The RHS Plan allows for money to be set aside during your employment with the City, which will then be available to both you and your legal dependents for eligible medical expenses upon your retirement or separation from service. Contributions to the plan may include:

- Direct-employer contributions in a lump sum or on a fixed-periodic basis
- Mandatory payroll deductions.

You can begin to use the benefits in the plan when you leave the City. If you should die before using the entire balance of your account, the remaining amount in your account is transferred to your surviving spouse and covered dependents for reimbursement of qualified medical expenses.
Retirement Savings Plan

The City's retirement plan is provided through California Public Employees' Retirement System (CalPERS). The contribution amounts you and the City make under this plan are based on your employee unit of representation and hire date into CalPERS. CalPERS invests these contributions on your behalf.

The City offers retirement benefits through CalPERS for the employees in the following bargaining units:

- **Miscellaneous:** At age 55, the benefit you receive is a factor of 2.7% of your salary times years of service.

- **Safety:** At age 50, the benefit you receive is a factor of 3% of your salary times years of service.

  Employees who were hired into CalPERS on or after January 1, 2013 receive benefits according to a different schedule. For miscellaneous employees, at age 62 they’ll receive a benefit that is a factor of 2% of their salary times years of service. For safety employees, at age 57 they’ll receive a benefit that is a factor of 2.7% of their salary times years of service.

In addition, the City contracts with CalPERS for these additional benefits:

- 1959 Survivor Benefit — Level 4
- Optional Settlement 2 Death Benefit
- 12-Month Final Compensation (36 Months for employees hired into CalPERS on or after January 1, 2013)
- Post-Retirement Survivor Continuance
- Sick Leave Credit
- Military Service Credit
- $5,000 Retired Death Benefits.

You can learn more about the retirement plan by visiting [www.calpers.ca.gov](http://www.calpers.ca.gov).
Deferred Compensation (457) Plan

Along with the Retirement Savings Plan, you can contribute on a pre-tax and/or after-tax Roth basis to a deferred compensation plan offered by the City and administered by ICMA-RC. With this plan, you have the flexibility to save additional funds for retirement. Participation in the deferred compensation plan is voluntary.

The 2016 contribution limits were:

- Regular contribution: $18,000 annually ($692.31 on a biweekly basis)
- Age 50 “catch-up” contribution: Up to an additional $6,000 annually.

If you haven’t been contributing the maximum contribution amount to your Deferred Compensation Plan in previous years, you may be eligible to make regular catch-up contributions within four years prior to retirement. Regular catch-up contributions allow you to contribute up to twice the federal contribution limit. For 2016, the regular catch-up contribution limit was $36,000. Please contact Human Resources Deferred Compensation staff for more information.

These limits may change for 2017, so please contact Human Resources to confirm the limits and for more plan details.

You can also find more information about the Deferred Compensation (457) plan by visiting www.icmarc.org/anaheim.
Get Healthy

Vitality: Know Your Health, Improve Your Health, Enjoy the Rewards

The City is proud to partner with The Vitality Group to offer wellness programs that can help you live the healthiest life you can. Our wellness program is focused on three key steps to help you achieve your wellness goals.

**Key Step 1: Know Your Health**
The first key step is to know yourself, your health risk factors and your goals. Vitality offers several activities to help you discover more about yourself.

- **Vitality Check™ Biometric Screening** (partnered with Quest Diagnostics) — The results of this screening can help you understand your health from the inside out and will become the baseline for your Vitality Personal Pathway to better health. Share the results with your doctor to take charge of your health.

  To register for your biometric screening, log in to [https://my.blueprintforwellness.com](https://my.blueprintforwellness.com) or call (866) 908-9440.

- **Vitality Health Review™ and Mental Well-being Review™** — These online health assessments available through the Vitality portal are confidential tools that assist you in evaluating your overall health and well-being.

  To access these reviews, visit [www.PowerofVitality.com](http://www.PowerofVitality.com).

- **Vitality Age™** — Based on your risk factors, current lifestyle and medical history, Vitality can tell you how old your body is compared to your real age.
Key Step 2: Improve Your Health
Once you know your numbers, the key to wellness is doing something about them. Vitality has activities to help you engage in and improve your health.

- **Personal Pathways™** — Based on results of your Biometric Screening and Vitality Age, Vitality will automatically create a personalized plan of next steps, based on your risks, to help you reach your goal of becoming a healthier you.

- **Track Your Activity** — Vitality offers a number of tools to help you track all of your physical activity, whether it’s working out at the gym, going for a hike, or taking a walk.

- **Vitality HealthyFood™** — Vitality rewards you for making healthy food purchases at more than 70 grocery store chains and WalMart® stores.

- **TrestleTree Lifestyle Coaching** — When you set a goal to stop smoking, lose weight or use stress-management techniques, lifestyle coaching is available to help you achieve your goals.

Key Step 3: Enjoy the Rewards
While feeling better and lowering your risk of chronic disease are huge rewards, Vitality wants to make sure you feel extra-rewarded when you take care of yourself. Here’s how:

- **First: Earn Vitality Points™** — When you complete almost any healthy activity, you’ll earn Vitality Points. You’ll receive Vitality Bucks for all the Vitality Points you earn.

- **Next: Learn Your Vitality Status®** — The higher your level of Vitality Points, the higher your Vitality Status, and the more rewards available to you. Status levels are Blue, Bronze, Silver, Gold and Platinum.

- **Then: Shop at the Vitality Mall™** — Use your Vitality Bucks to buy items at the Vitality Mall, such as fitness devices and equipment, home goods and more. The higher your Vitality Status, the greater your discount at the Vitality Mall.

- **The final step: Earn Your Vitality Wellness Premium Credits** — The Vitality Status you achieve by the end of the year can have a real impact on how much you pay for your City medical coverage next year. Discounts start when you reach the Silver status level and increase at each level.

To learn more about the City’s Vitality Wellness Program, visit [www.PowerofVitality.com](http://www.PowerofVitality.com).
YOUR 2017 BENEFITS GUIDE

Another Option to Know Your Health
The City’s medical plan carriers also offer you the opportunity to learn more about your current health so that you can set meaningful goals to improve it.

1. **Get a biometric screening.** Biometric screenings measure your height, weight, waist size, cholesterol, blood sugar, and blood pressure. They help you and your doctor track your progress and identify potential health risks that you can address now.

2. **Complete a Health Risk Assessment (HRA).** The HRA asks you a series of questions about your health, then gives you personalized information about what you’re doing well and which aspects of your health you can improve. These results can help you make healthy decisions and reduce your risk factors.

To take the HRA, follow the instructions below:

<table>
<thead>
<tr>
<th>If You’re an Aetna Member…</th>
<th>If You’re a Kaiser Member…</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Visit <a href="http://www.aetna.com">www.aetna.com</a></td>
<td>1 Visit <a href="http://www.kp.org">www.kp.org</a>*</td>
</tr>
<tr>
<td>2 Log on to Aetna Navigator with your login information*</td>
<td>2 Click “My Health Manager”</td>
</tr>
<tr>
<td>3 Click “Take a Health Assessment,” then “Launch My Health Assessment” to begin</td>
<td>3 Click “Total Health Assessment,” then “Start Total Health Assessment Now” to begin</td>
</tr>
</tbody>
</table>

* If you haven’t registered, create a profile by clicking the New Member registration link

* If you haven’t registered, visit [www.kp.org](http://www.kp.org) and click Register to get a user ID
Carrier Tools
If you enroll in an Aetna or Kaiser plan, you have access to a number of resources to help you improve your overall health and wellness and become better informed about your health and health care.

Aetna’s Tools
Aetna’s website is a great resource, not only for details about your plan but also for general health and wellness information. In addition to searchable provider and facility directories and a list of drugs on the prescription drug formulary, you can use www.aetna.com to find details about your benefit levels, download claim forms, and search your claims history.

When you log on to the Aetna Navigator site, you can also order medications through the mail-order pharmacy and print temporary ID cards. Another useful tool is the health care cost estimator, which provides an estimated cost for office visits, surgeries, and treatment for certain diseases, as well as prescription drug costs.

<table>
<thead>
<tr>
<th>Aetna SmartSource</th>
<th>Aetna’s SmartSource is an online tool to help you find information about a particular disease or condition, and includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Local physicians who specialize in treating specific diseases</td>
</tr>
<tr>
<td></td>
<td>• Medication and treatment options</td>
</tr>
<tr>
<td></td>
<td>• Estimated costs for treatment.</td>
</tr>
<tr>
<td></td>
<td>By using the tools available, you’ll be able to better manage your condition and receive the care you need. Log in to <a href="http://www.aetna.com">www.aetna.com</a> to access Aetna SmartSource.</td>
</tr>
</tbody>
</table>

| Personal Health Records | This secure online resource makes it easy for you to view and manage all your health information, and even share it with your doctors. |
| Simple Steps for a Healthier Life | Want to lead a healthier life but don’t know where to begin? This program will help you learn the simple steps you can take to lose weight, eat better, relieve stress, and much more. |
### Aetna’s Tools

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Teladoc Consultation Services</strong></td>
<td>Get 24/7 access to physicians through Teladoc, Aetna’s telemedicine program. Through this service you can get advice from certified doctors about your care. You pay a copay when you need to use the service, and you can speak with a doctor at any time. For members enrolled in the OAMC plan, you pay a $20 copay for each visit with an in-network primary care physician, and $40 for each visit with an in-network specialist. For HSA OAMC members, you pay 20% coinsurance for each visit with an in-network primary care physician or specialist. Beginning January 1, 2017, Teladoc is available for HMO plan members as well. If you are an HMO member, you’ll pay a $40 copay for each visit (in-network doctors only). Go to <a href="http://www.teladoc.com/Aetna">www.teladoc.com/Aetna</a> to use Teladoc. You can also call the Informed Health Line at 800-556-1555.</td>
</tr>
<tr>
<td><strong>Informed Health® Line</strong></td>
<td>Aetna’s Informed Health® Line is a 24/7 service that provides you and your family with round-the-clock access to registered nurses who provide information about health issues, medical procedures and treatment options, and can help you communicate more effectively with your doctor. You can access the Informed Health® Line by calling 800-556-1555.</td>
</tr>
<tr>
<td><strong>CarePass® — Your New Online and Mobile Wellness Tool</strong></td>
<td>Because everyone’s journey is unique, Aetna has created the CarePass® online and mobile destination to be your guide as you journey to get healthier. The CarePass® health and wellness tool will help you set meaningful health goals, discover apps that help you achieve the goals and see a picture of your whole health in one convenient and secure location. To begin your journey with CarePass®, go to <a href="http://www.CarePass.com">www.CarePass.com</a> or directly from your Aetna Navigator home page.</td>
</tr>
</tbody>
</table>
When you enroll in a Kaiser medical plan, you have access to some great online tools through www.kp.org.

<table>
<thead>
<tr>
<th>Tool</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Health Manager</td>
<td>Get access to your health and health plan information in one safe, convenient place.</td>
</tr>
<tr>
<td>Online Health Programs</td>
<td>Programs through HealthMedia to help you manage conditions, lose weight, quit smoking, and take other steps to improve your health.</td>
</tr>
<tr>
<td>Health and Drug Encyclopedias</td>
<td>Get information about various conditions, medications, and health topics.</td>
</tr>
<tr>
<td>Contact a Professional</td>
<td>You can send a confidential question to a health professional.</td>
</tr>
<tr>
<td>Message Boards</td>
<td>Where you can go to facilitate online discussions with other Kaiser members on a variety of health and wellness topics.</td>
</tr>
<tr>
<td>Directory</td>
<td>A searchable provider directory.</td>
</tr>
</tbody>
</table>
Tips for Using Your Benefits Wisely

Are you wondering how you can start improving your wellness today? In addition to taking advantage of the City’s resources through Anaheim in Motion, you can also take steps to get the most out of your medical coverage. This can even help you save money on health care costs! Start following these tips today:

<table>
<thead>
<tr>
<th>Tip</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use preventive care benefits</td>
<td>Health checks, flu shots, and a variety of other discounted and free services are provided by the City and your medical plans. Preventive care addresses your wellness needs today, and reduces your risk for future health problems and unexpected costs. Remember, preventive care is 100% covered when you use in-network providers!</td>
</tr>
<tr>
<td>Visit an urgent care facility instead of the ER</td>
<td>If you’re experiencing a true, life-threatening emergency, don’t think twice about going to the emergency room. If your condition is not life-threatening, you’ll pay less and experience less waiting time by choosing an urgent or after-hours care center.</td>
</tr>
<tr>
<td>Use Aetna’s online tools</td>
<td>Visit <a href="http://www.aetna.com">www.aetna.com</a> and click the purple “Log In” box to use Aetna Navigator. You can locate high-quality doctors and other providers; and you can also find out how much office visits, tests, and other health care services cost.</td>
</tr>
<tr>
<td>Use Kaiser’s online healthy living tools</td>
<td>You may be able to save yourself an office visit! Visit <a href="http://www.kp.org">www.kp.org</a> to get answers to your health questions from your own doctor; or take a self-guided healthy living course.</td>
</tr>
<tr>
<td>Choose generic drugs</td>
<td>A generic drug is often as effective as its brand-name counterpart and costs less to produce. These savings are passed on to you, and your co-pay will be less when you ask for the generic equivalent of your prescription drug.</td>
</tr>
<tr>
<td>Check out a Lifestyle Management Program</td>
<td>Both Kaiser and Aetna offer free online action-oriented programs designed to help you modify a lifestyle factor and/or facilitate behavior change. These programs move at your pace to focus on the issues that matter to you, like weight management, stress management, smoking cessation, and nutrition.</td>
</tr>
</tbody>
</table>
Get Enrolled

If eligible, you can enroll for benefits:
- During Open Enrollment
- As a new full-time hire
- During the year, under certain circumstances.

Enrolling During Open Enrollment

Open Enrollment is the time to review your plan options and make sure you're enrolled in the coverage that best meets your and your family's needs. The health and welfare benefits plans you choose during Open Enrollment are in effect for the entire plan year — January 1 through December 31.

Full-Time Status

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Benefit Plans</th>
</tr>
</thead>
</table>
| Your first day of employment (you must enroll in FSAs within 30 days of eligibility) | - Employee Assistance Program (EAP)  
- Retirement Health Savings Account (RHS)  
- CalPERS Retirement Plan  
- Flexible Spending Accounts (FSAs)  
- Deferred Compensation (457) Plan |
| The first day of the month following one month of eligibility (you must enroll within 30 days of becoming eligible) | - Medical/vision coverage |
| Following three months of eligibility (you must enroll for Supplemental Life Insurance within 30 days of becoming eligible) | - Basic Life Insurance  
- Basic AD&D Insurance  
- Supplemental Life Insurance |
| Following six months of eligibility | - Short-Term Disability (STD)  
- Long-Term Disability (LTD) |
| The first day of the month following six months of eligibility (you must enroll within 30 days of becoming eligible) | - Dental coverage |
Enrolling During the Year

In general, you may make changes to your health and welfare benefits plans coverage during the year only if you have a qualifying event. “Qualifying events” include:

- Marriage or divorce
- Entering into or terminating a domestic partnership
- Birth or adoption of a child (must be added within 30 days of birth or adoption, a birth certificate will be required)
- Death of spouse or dependent
- Loss or gain of coverage due to a plan termination or change in employment status
- Change in your, your spouse’s, your registered domestic partner’s, or your dependent’s employment status
- Your dependent child’s reaching the maximum eligibility age
- Change in residence
- Change in cost for an employer-provided plan, except for the Health Care Flexible Spending Account.

If you have a qualifying event, you have 30 days to notify Human Resources and to provide documentation to the Benefits Department in order to make the appropriate benefit changes.
Special Enrollment Rights — Other Qualifying Events

There are a few other scenarios in which you can change your health and welfare benefits during the year:

- When the benefit plan year of a spouse’s, registered domestic partner’s, or dependent child’s employer-provided benefit plan differs from your benefit plan year;
- When a dependent child turns 13 years old, for employees who participate in the Dependent Care Flexible Spending Account;
- When certain cost changes occur related to a dependent child’s day care provider, for employees who participate in the Dependent Care Flexible Spending Account;
- If you or your eligible dependents lose Medicaid or Children’s Health Insurance Program (CHIP) coverage because you’re no longer eligible; or
- If you become eligible for a state’s premium assistance program under Medicaid or CHIP.

Remember, it’s your responsibility to notify Human Resources when dependents are no longer eligible for benefits. Failure to properly notify Human Resources regarding qualifying events may subject you to repayment of costs of covering ineligible dependents.

In an effort to help manage our increasing healthcare costs, please be sure to verify that your enrolled dependents are considered eligible under the City’s health benefits program. Your dependents include your spouse, domestic partner, and any children under age 26. The City will be conducting a more thorough review of covered dependents in 2017.

If you wish to make benefit changes during the year, you must notify Human Resources within 30 days of the qualifying event. Any benefit changes you make must be consistent with your qualifying event.
How to Enroll — ESS

If you want to make benefits changes, you must complete online enrollment through our Employee Self-Service (ESS) system. Online enrollment is available 24/7 from work or from home during the Open Enrollment period.

To log on to the ESS:

- Go to [http://myinfo.anaheim.net](http://myinfo.anaheim.net) by clicking the link to the left or entering it in the address bar of your web browser.
- Click the Login button.
- Enter your User Name and Password (case sensitive).
  - **User Name:** Your user name is your six-character employee ID, which can be found on your personalized cover letter in your Open Enrollment packet.
  - **Password:** Your password is your regular ESS password. If you’ve forgotten your password, click “forgot your password” to have your password emailed to you. If you need further assistance, contact the help desk at 714-765-5104.

For benefit questions and assistance, contact the Human Resources Benefits Division at 714-765-5185.
YOUR Eligibility
You're eligible to participate in the City of Anaheim benefits plans outlined in this Benefits Guide if you're regularly scheduled to work 30 or more hours a week.

Your Dependents
You may enroll your eligible family members in the same health and welfare plans you elect for yourself. Eligible family members include:

- Your legal spouse or your California-registered domestic partner
- Your or your spouse/registered domestic partner's dependent children under age 26 (including stepchildren, foster children, and children under legal guardianship arrangements). A birth certificate will be required for added dependents under the age of 26.
- Your or your spouse/registered domestic partner's dependent children 26 and older who are incapable of self-support because of a mental or physical disability.

If you want to cover a dependent child who's living away from home, carefully check the plan you're selecting to make sure your child's home is within the plan's service area. If it's not within the plan's service area, your child may be covered only for emergency care. However, if you enroll in one of the Aetna plans, your dependents will be eligible for out-of-area benefits for routine and emergency care.

It's your responsibility to notify Human Resources when your dependents are no longer eligible for benefits.

For more information on dependent eligibility, check with Human Resources.
Paying for Benefits

Depending on the benefit, either you or the City will pay the full cost of coverage or you and the City will split the cost of coverage. For example:

- Generally the City pays for the full cost for benefits such as Short- and Long-Term Disability. (Note: If you’re part of the Police APA unit, you pay the full cost of Long-Term Disability coverage.)

- You and the City share the cost of some plans, including medical/vision, dental, and Basic Life Insurance. You pay your share of these costs with deductions taken from your paycheck on a pretax basis. (Note: If you’re a part of the Police APA unit, Basic Life Insurance is paid as part of union dues.)

- You pay the full cost of Supplemental Life Insurance with deductions from your paycheck on an after-tax basis.

Don't Need Medical Coverage? Get Cash Back.

If you're covered under another medical plan, you may decline City-sponsored medical coverage. If you decline medical coverage, you:

- Will receive $125 in taxable income added to your paycheck each month (proof of other medical coverage required)
- Must decline medical coverage for any family members
- Won’t be covered for vision or behavioral health benefits (however, you’re still eligible for the REACH employee assistance plan)
- May enroll for dental coverage for yourself and any eligible family members
- Can’t change your decision to decline coverage for yourself or your family until the next Open Enrollment period unless you have a qualifying event (see Enrolling During the Year for a list of qualified changes in status).

Keep in mind, the Affordable Care Act requires you have medical coverage or pay a penalty. If you decline City-sponsored medical coverage, be sure to consider other options for coverage.
## 2017 Medical Plan Cost

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Total Monthly Cost</th>
<th>City Monthly Contribution</th>
<th>Employee Monthly Contribution</th>
<th>Employee Per Pay Period Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Kaiser HMO</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$ 524.44</td>
<td>$ 471.08</td>
<td>$ 53.36</td>
<td>$ 26.68</td>
</tr>
<tr>
<td>Two-Party</td>
<td>$ 1,048.88</td>
<td>$ 942.08</td>
<td>$ 106.80</td>
<td>$ 53.40</td>
</tr>
<tr>
<td>Family</td>
<td>$ 1,484.16</td>
<td>$ 1,333.06</td>
<td>$ 151.10</td>
<td>$ 75.55</td>
</tr>
<tr>
<td><strong>Aetna HMO</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$ 748.53</td>
<td>$ 651.63</td>
<td>$ 96.90</td>
<td>$ 48.45</td>
</tr>
<tr>
<td>Two-Party</td>
<td>$ 1,500.17</td>
<td>$ 1,310.47</td>
<td>$ 189.70</td>
<td>$ 94.85</td>
</tr>
<tr>
<td>Family</td>
<td>$ 2,121.82</td>
<td>$ 1,845.14</td>
<td>$ 276.68</td>
<td>$ 138.34</td>
</tr>
<tr>
<td><strong>Aetna OAMC Plan</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$ 1,258.18</td>
<td>$ 957.44</td>
<td>$ 300.74</td>
<td>$ 150.37</td>
</tr>
<tr>
<td>Two-Party</td>
<td>$ 2,516.39</td>
<td>$ 1,907.73</td>
<td>$ 608.66</td>
<td>$ 304.33</td>
</tr>
<tr>
<td>Family</td>
<td>$ 3,560.68</td>
<td>$ 2,685.04</td>
<td>$ 875.64</td>
<td>$ 437.82</td>
</tr>
<tr>
<td><strong>Aetna HSA OAMC Plan</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$ 1,061.05</td>
<td>$ 838.83</td>
<td>$ 222.22</td>
<td>$ 111.11</td>
</tr>
<tr>
<td>Two-Party</td>
<td>$ 2,122.08</td>
<td>$ 1,672.30</td>
<td>$ 449.78</td>
<td>$ 224.89</td>
</tr>
<tr>
<td>Family</td>
<td>$ 3,002.75</td>
<td>$ 2,353.65</td>
<td>$ 649.10</td>
<td>$ 324.55</td>
</tr>
</tbody>
</table>

## 2017 Dental Plan Cost

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Total Monthly Cost</th>
<th>City Monthly Contribution</th>
<th>Employee Monthly Contribution</th>
<th>Employee Per Pay Period Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DeltaCare USA DHMO Plan</strong></td>
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Contact Information

For more information about any of the benefits described in this guide, you can contact the plan carrier directly or call the Benefits Office.

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<tr>
<th>Plan/Department</th>
<th>Contact Name/Department</th>
<th>Group Number</th>
<th>Website</th>
<th>Phone Number</th>
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<tr>
<td>Human Resources</td>
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<td>Aetna HMO</td>
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<td>800-765-6003</td>
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<td>Flexible Spending Accounts</td>
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<td>888-678-8242</td>
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<td>866-945-7801</td>
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<td>Life Insurance</td>
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<td>[website]</td>
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<td>Accidental Death &amp; Dismemberment</td>
<td>The Hartford</td>
<td>395232</td>
<td>[website]</td>
<td>800-572-9047</td>
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Legal Notices

The following are legal notices regarding your rights under the City-sponsored health and welfare plans. The City is required to provide this information to you.

Medicare Creditable Coverage Notice
If you (and/or your dependent) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. See “Important Notice from The City of Anaheim About Your Prescription Drug Coverage and Medicare” on the next page for details.

Availability of Summary Health Information
As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, the City provides a 2017 Employee Benefits Summary Comparison Chart. In addition, your plan makes available an online Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBCs are available on the City’s Benefits Website — www.myanaheimbenefits.com.
Kaiser HMO: Notice of Grandfathered Status

The City of Anaheim believes the Kaiser HMO is a “grandfathered health plan” under the PPACA. As permitted by the PPACA, grandfathered health plans can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Kaiser HMO medical plans may choose not to immediately include certain PPACA-mandated features that apply to other plans — for example, the requirement that preventive health care be offered without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the PPACA — for example, the change in dependent age eligibility.

Questions regarding which protections apply and which protections don’t apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Human Resources Department.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and don’t apply to grandfathered health plans.

Important Notice from The City of Anaheim (the City) About Creditable Prescription Drug Coverage and Medicare

Click here to review the Notice of Creditable Coverage.

Please read this notice carefully. It has information about prescription drug coverage with the City and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.
Women’s Health and Cancer Rights Act of 1998

If you or one of your covered dependents has had or is going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided for the following services in a manner determined in consultation with the attending physician and the patient:

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

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

For information on WHCRA benefits or details about any state laws that may apply to your medical plan, please refer to the benefit plan material for the medical plan in which you are enrolled.
Newborns’ and Mothers’ Health Protection Act

Federal law protects the benefit rights of mothers and newborns related to any hospital stay in connection with childbirth. In general, group health plans and health insurance issuers may not:

- Restrict benefits for the length of hospital stay for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours after delivery (or 96 hours, as applicable).

- Require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay of up to 48 hours after delivery (or 96 hours).

For details on any state maternity laws that may apply to your medical plan, please refer to the benefits material for the medical plan in which you are enrolled.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice Reminder

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require the City’s Health and Welfare Benefit Plans (the “Plan”) to periodically send a reminder to participants about the availability of the Plan’s privacy notice and how to obtain that notice. The privacy notice explains participants’ rights and the Plan’s legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI.

To obtain a copy of the privacy notice, contact Human Resources.
Special Enrollment Events

Special enrollment events allow you and your eligible dependents to enroll for health coverage outside the Open Enrollment period under certain circumstances if you lose eligibility for other coverage, become eligible for state premium assistance under Medicaid or the Children’s Health Insurance Program (CHIP), or acquire newly eligible dependents. This is required under the Health Insurance Portability and Accountability Act (HIPAA).

If you decline enrollment in a City medical plan for you or your dependents (including your spouse/domestic partner) because of other health insurance coverage, you or your dependents may be able to enroll in a City medical plan without waiting for the next Open Enrollment period if you:

- Lose other coverage. You must request enrollment within 31 days after the loss of other coverage;
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption; or
- Lose Medicaid or Children’s Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day time frame, coverage will be effective the date of birth, adoption, or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in a City of Anaheim medical plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain such coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

**Note:** If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another medical plan. Any other currently covered dependents may also switch to the new plan in which you enroll.
Consolidated Omnibus Budget Reconciliation Act (COBRA)

If you’re an employee with medical, dental, or vision coverage through the City, you have the right to choose continuation coverage if you lose your group health coverage due to reduction in your hours of employment or the termination of your employment for reasons other than gross misconduct. Your eligible dependents may also have the right to elect and pay for continuation of coverage for a temporary period in certain circumstances where coverage under the plan would otherwise end, such as divorce, or dependent children who no longer meet eligibility requirements.

Important Notice: This brief summary of the right you and your dependents have to continue insurance is not intended as the official notice of your rights required by federal and state law. We've included this brief summary to inform you that you have these rights. You’ll receive a separate, detailed explanation of your right to continue health insurance coverage when applicable. Specific information is also available from the City Human Resources Department.
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, you can contact your state Medicaid or CHIP office to find out if premium assistance is available, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov or CoveredCA.com.

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

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

In California, you may be eligible for assistance paying your employer health plan premiums. Contact the state for further information on eligibility.

- CALIFORNIA — Medicaid
  Website: www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Notice of Coverage Rescission

For plan years beginning after September 23, 2010 (i.e., January 1, 2011, for a calendar-year plan), this group health plan is prohibited from retroactively terminating (rescinding) benefits coverage except in cases of non-payment of premium, fraud, intentional misrepresentation, or omission of material facts relevant to such benefits coverage. The rescission rule can apply to a single person, an individual within a family, or an entire group of people.

If this group health plan rescinds your coverage, to the extent required by law, you will be provided with at least 30-days prior written notice of the coverage rescission and the right to appeal. For more information, contact any member of the Human Resources team.

Health Insurance Marketplace Coverage Options and Your Health Coverage

The Affordable Care Act (ACA) requires that the City provide you with the attached notice, which describes the new health insurance marketplaces. A “health insurance marketplace” is an online, government-sponsored public shopping site where you can buy health insurance. The notice also describes how our medical plans meet ACA affordability and benefits requirements for employees who work 30 hours or more per week.