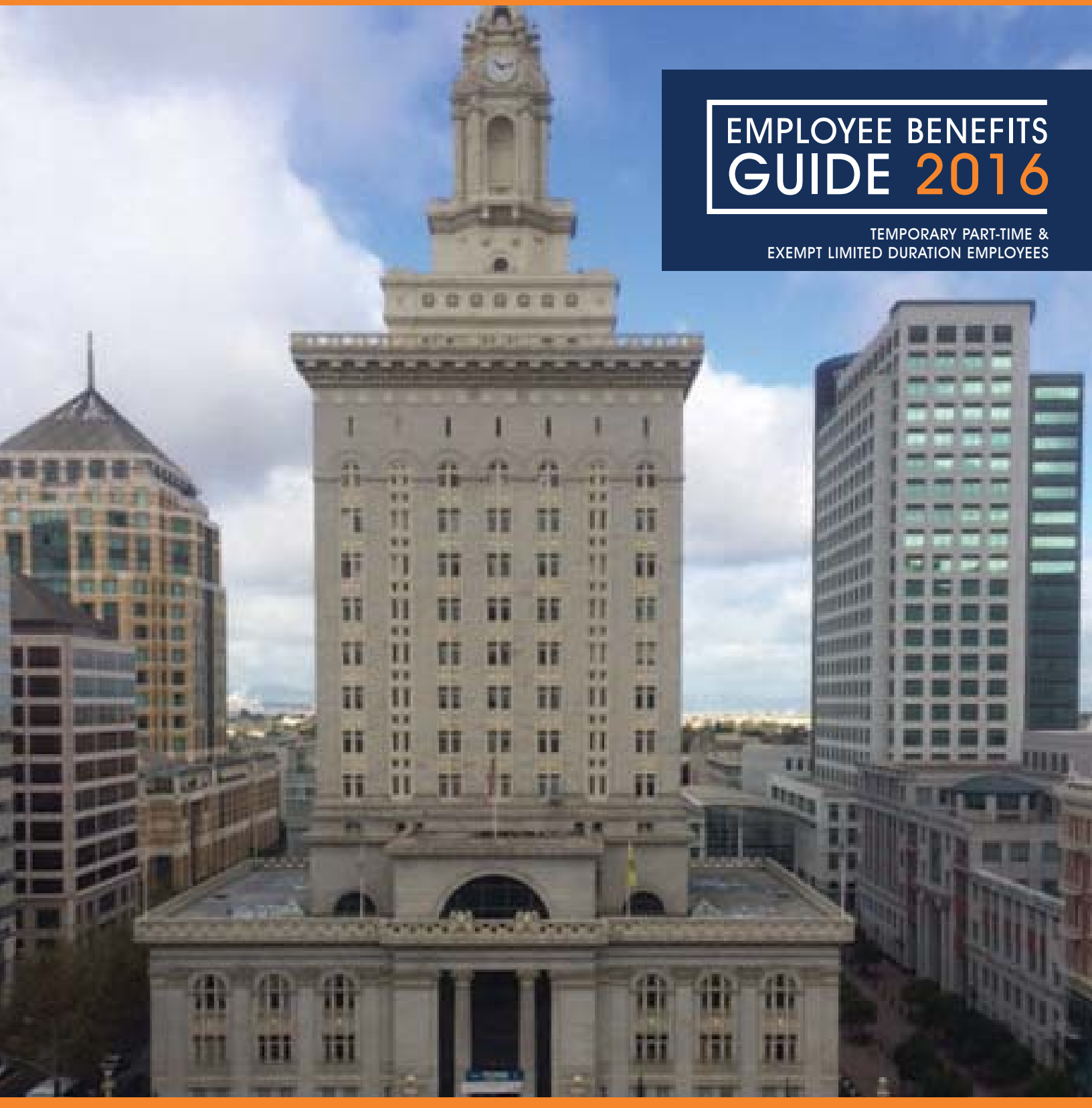

EMPLOYEE BENEFITS GUIDE 2016

TEMPORARY PART-TIME &
EXEMPT LIMITED DURATION EMPLOYEES

CITY OF OAKLAND

EMPLOYEE BENEFITS
GUIDE 2016




what's inside

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.

CONTACT INFORMATION

Employee Benefits Program	Benefits Representative	Contact Information
Risk and Benefits Administration	Deborah Grant, Manager	510.238.7165 dgrant@oaklandnet.com
Deferred Compensation	Michael McGhee ICMA-RC (Investment Option Inquiry Only)	510.238.6485 mmcghee@icmarc.org
	Lisa Lavatai	510.238.6769 llavatai@oaklandnet.com
Medical and Dental Insurance	Michael K. Lee	510.238.2248 mlee@oaklandnet.com
Ergonomics	Mike Spade	510.238.7971 mspade@oaklandnet.com
Fair Employment Housing Act (FEHA) Americans for Disabilities Act (ADA) Workers' Compensation	Mary Baptiste	510.238.2270 mbaptiste@oaklandnet.com
	Annie Chin	510.238.4958 achin@oaklandnet.com
Family Medical Leave Act (FMLA)	Donella Williams	510.238.6448 dwilliams3@oaklandnet.com
Sun Life Insurance	Gloria Alcala	510.238.7445 galcala@oaklandnet.com
Non-PERS Kaiser	Michael K. Lee	510.238.2248 mlee@oaklandnet.com
Safety, Health and Wellness	Greg Elliott	510.238.4993 gelliott@oaklandnet.com
SDI Disability Insurance (EDD) (Non-Sworn)	Lisa Lavatai	510.238.6769 llavatai@oaklandnet.com
Vision (Non-Sworn)	Gloria Alcala	510.238.7445 galcala@oaklandnet.com

Benefit information and forms can be located at oaknetnews/HR-SelfServe/OPENENROLLMENT/index.htm.

CALENDAR

2015

JANUARY

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JANUARY
1 New Year's Day
19 Martin Luther King Jr.'s Day

FEBRUARY
12 Lincoln's Birthday
16 President's Day

MAY
25 Memorial Day

JULY
4 Independence Day (HVA)

SEPTEMBER
7 Labor Day
9 Admission's Day

NOVEMBER
11 Veteran's Day
26 Thanksgiving Day
27 Day after Thanksgiving Day

DECEMBER
25 Christmas Day

JULY

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INTRODUCTION

As Temporary Part-Time Employees with the City of Oakland, you 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 Death Benefit Beneficiary Designation.

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.

ELIGIBILITY

Active Employment

Employees who are eligible to participate in the Non-PERS Kaiser medical, vision and dental group insurance plans are limited-duration employees with an appointment of six (6) months or less. Temporary part-time employees are not eligible for dental or vision benefits through the City of Oakland. However, coverage may be available through the Covered California Program. Please see pages 22 & 23 of this Guide for more information.

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)

ENROLLMENT

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.

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

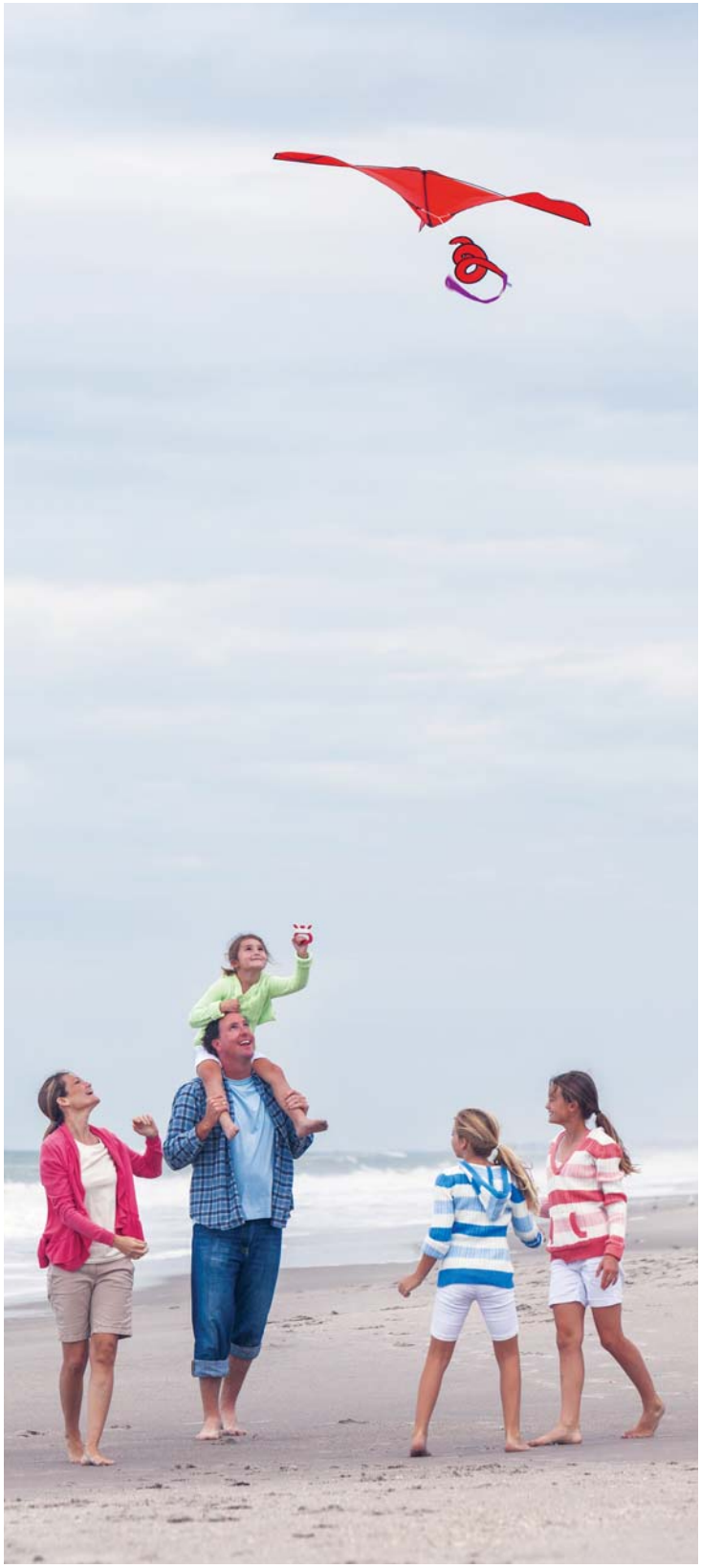
- ELDE Employee Benefits Record form
- Death Benefit Benficiary Designation Form

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.

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 most beneficiary forms from Human Resources. You can designate a beneficiary for:

- Deferred Compensation
- Death Benefit



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.
- You, your spouse/domestic partner or your dependents lose COBRA coverage.
- Your spouse/domestic partner employer provides the opportunity to enroll or change benefits during an open enrollment period.

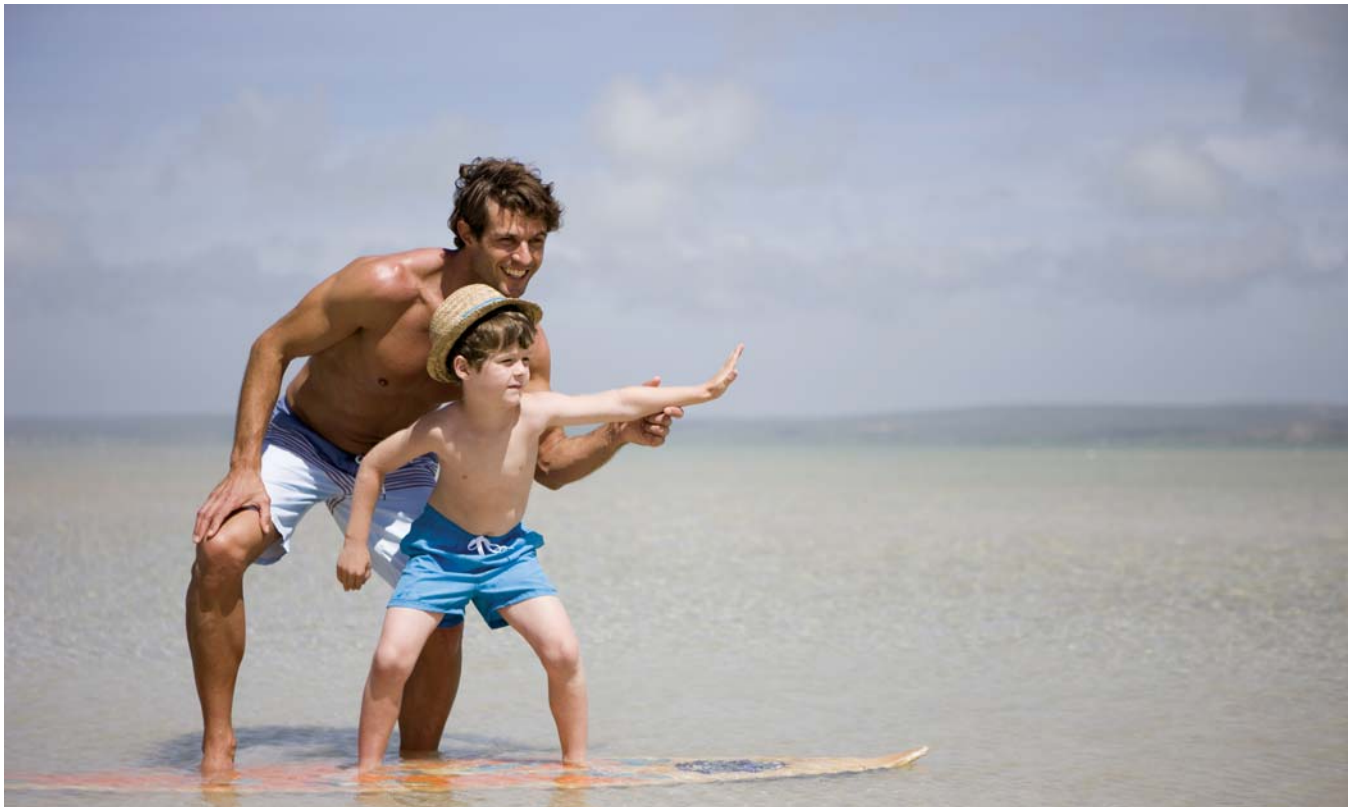
Special Enrollment Rights as Provided by HIPAA

- 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.

TEMPORARY PART-TIME BENEFITS

DEATH BENEFIT FOR 1021 REP UNIT MEMBERS ONLY

Effective December 22, 2004, the City agrees to provide a three thousand ($3,000) death benefit for each such unit employee, payable to the designated beneficiary, upon the death of the unit member while employed by the City.



EXEMPT LIMITED DURATION EMPLOYEE BENEFITS

MEDICAL – NON-CALPERS

Eligible employees are Exempt Limited Duration Employees with six months of service or less.

Plan Benefits	Kaiser Permanente HMO
General Plan Information	
• Office Visits / Exam	$15 copay
• Outpatient Specialist Visit	$15 copay
• Annual Out-of-Pocket Limit	
– Individual	$1,500
– Family	$3,000
• Lifetime Plan Maximum	Unlimited
• Primary Care Physician Election Required	Yes
Preventive Services	
• Well Child Care	100%
• Immunizations	100%
• Well Woman Exams	$15 copay
• Mammograms	100%
• Adult Periodic Exams with Preventive Tests	$15 copay
• Diagnostic X-ray and Lab Tests	100%
Maternity Care	
• Pregnancy and Maternity Care (*Pre-Natal Care*)	100%
Inpatient Hospital Services	
• Inpatient Hospitalization	100%
• Pre-Authorization of Services Required	Yes
• Semi-Private Room & Board, Including Services and Supplies	100%
Surgical Services	
• Outpatient Facility Charge	$15 copay/procedure
Emergency Services	
• Emergency Room	$50 copay; waived if admitted
Ambulance	
• Air	100%
• Ground	100%
Urgent Care	
• Urgent Care Facility	$15 copay

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.

MEDICAL – NON-CALPERS (continued)

Plan Benefits	Kaiser Permanente HMO
Mental Health Benefits	
• Inpatient Care	100%
• Outpatient Care	$15 copay/individual treatment $7 copay/group treatment
Substance Abuse	
• Inpatient Detoxification Services	100%
• Outpatient Services	$15 copay/individual treatment $5 copay/group treatment
Prescription Drugs	
• Retail	
– Generic	$5 copay
– Brand *(Formulary / Preferred)*	$15 copay
– Number of Days Supply	100 days
• Mail Order	
– Generic	$5 copay
– Brand *(Formulary / Preferred)*	$15 copay
– Number of Days Supply	100 days
Other Services and Supplies	
• Durable Medical Equipment and Prosthetic Devices	100%
• Home Health Care	100% up to 100 visits/cal year
• Skilled Nursing or Extended Care Facility	100% up to 100 visits/cal year
• Hospice Care	100%
• Chiropractic Services	Not covered
• Acupuncture	$15 copay with prior authorization
Hearing	
• Screening	100%; hearing exam $15 copay
Infertility	
• Diagnosis	See plan document
• Treatment	See plan document
Outpatient Rehabilitative Therapy Services	
• Physical, Occupational, Speech	$15 copay

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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.

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.

Plan Benefits	DeltaCare USA
General Plan Information	
• Annual Deductible	
– Individual	$0
– Family	$0
• Waived for Preventive	N/A
• Annual Plan Maximum	N/A
• Lifetime Orthodontia Plan Maximum	N/A
Diagnostic and Preventive Services	
• Diagnostic and Preventive	$0 – $45 copay
• Oral Exams	100% covered
• Bitewing X-rays	100% covered
• Full Mouth X-rays	100% covered every 24 months
• Cleaning and Scaling	100% covered every six months
• Prophylaxis Treatments	100% covered every six months
• Fluoride Treatments	100% covered
• Space Maintainers	$10 copay
• Sealants	$5 copay; limited to permanent molars through age 15
Basic Services	
• Basic	$0 – $220 copay
• Oral Surgery *(Extractions and Other Surgical Procedures)*	$0 – $90 copay
• Endodontic Treatment	$0 – $220 copay
• Periodontic Treatment	$0 – $195 copay
• Re-linings and Re-basings of Existing Removable Dentures	$0 – $35 copay
• Repair or Re-cementing of Crowns, Inlays, Onlays, Dentures or Bridgework	$0 – $75 copay

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DENTAL (continued)

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

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DENTAL (continued)

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	Delta Dental PPO	
	In-Network	Out-of-Network
General Plan Information		
• Annual Deductible		
– Individual	$25	$25
– Family	$75	$75
• Waived for Preventive	No	No
• Annual Plan Maximum	$1,500	$1,500
• Lifetime Orthodontia Plan Maximum	$2,000	$2,000
Diagnostic and Preventive Services		
• Diagnostic and Preventive	100%	100%
• Oral Exams	100%	100%
• Bitewing X-rays	100%	100%
• Full Mouth X-rays	100%	100%
• Cleaning and Scaling	100%	100%
• Prophylaxis Treatments	100%	100%
• Fluoride Treatments	100%	100%
• Space Maintainers	100%	100%
• Sealants	100%	100%
Basic Services		$0
• Basic	100%	80%
• Oral Surgery *(Extractions and Other Surgical Procedures)*	100%	80%
• Endodontic Treatment	100%	80%
• Periodontic Treatment	100%	80%
• Re-linings and Re-basings of Existing Removable Dentures	100%	80%
• Repair or Re-cementing of Crowns, Inlays, Onlays, Dentures or Bridgework	100%	80%

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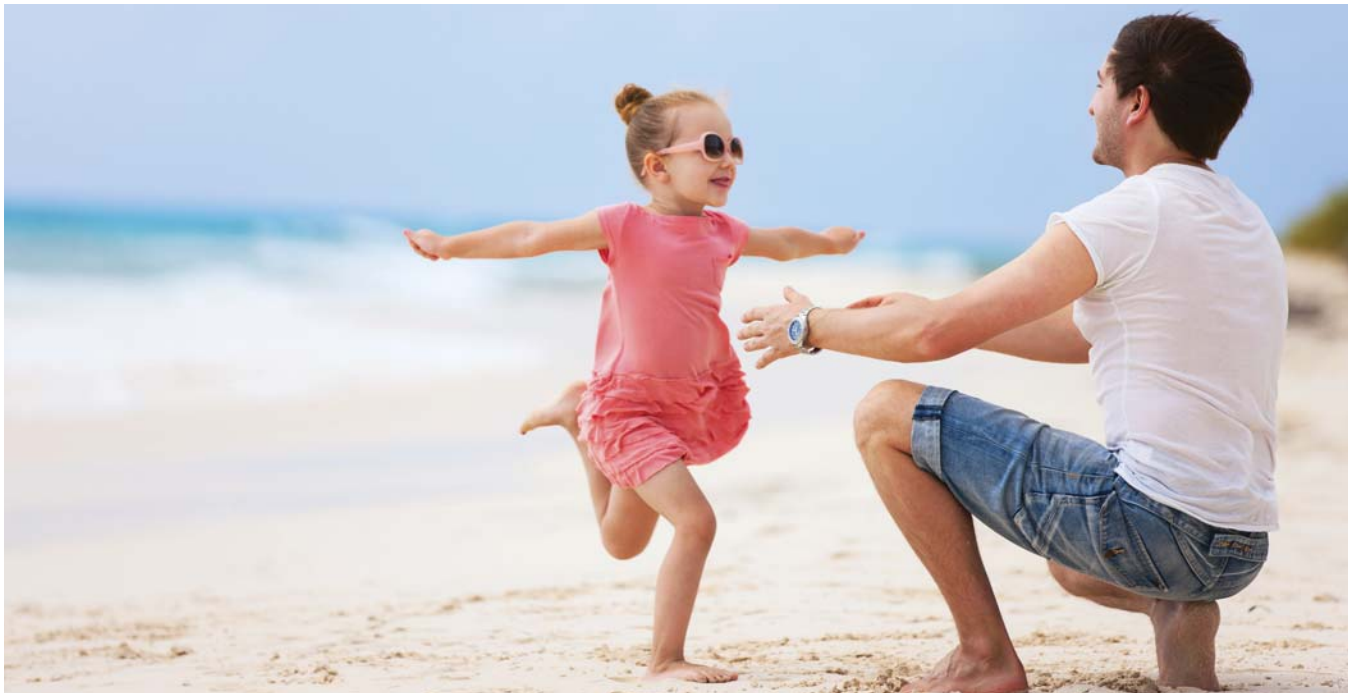
DENTAL (continued)

Plan Benefits	Delta Dental PPO	
	In-Network	Out-of-Network
Major Services		
• Major	60%	60%
• Crowns, Jackets and Cast Restorations	60%	60%
• TMJ	Not covered	Not covered
• Prosthodontic Benefits *(Fixed Bridges, Partial / Complete Dentures)*	60%	60%
• Implants	Not covered; see plan document	Not covered; see plan document
Orthodontia Services		
• Orthodontia	50%	50%
• Dependent Children	Covered	Covered
• Adults *(and Covered Full-Time Students, if eligible)*	Covered	Covered
• Adult Lifetime Maximum	$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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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

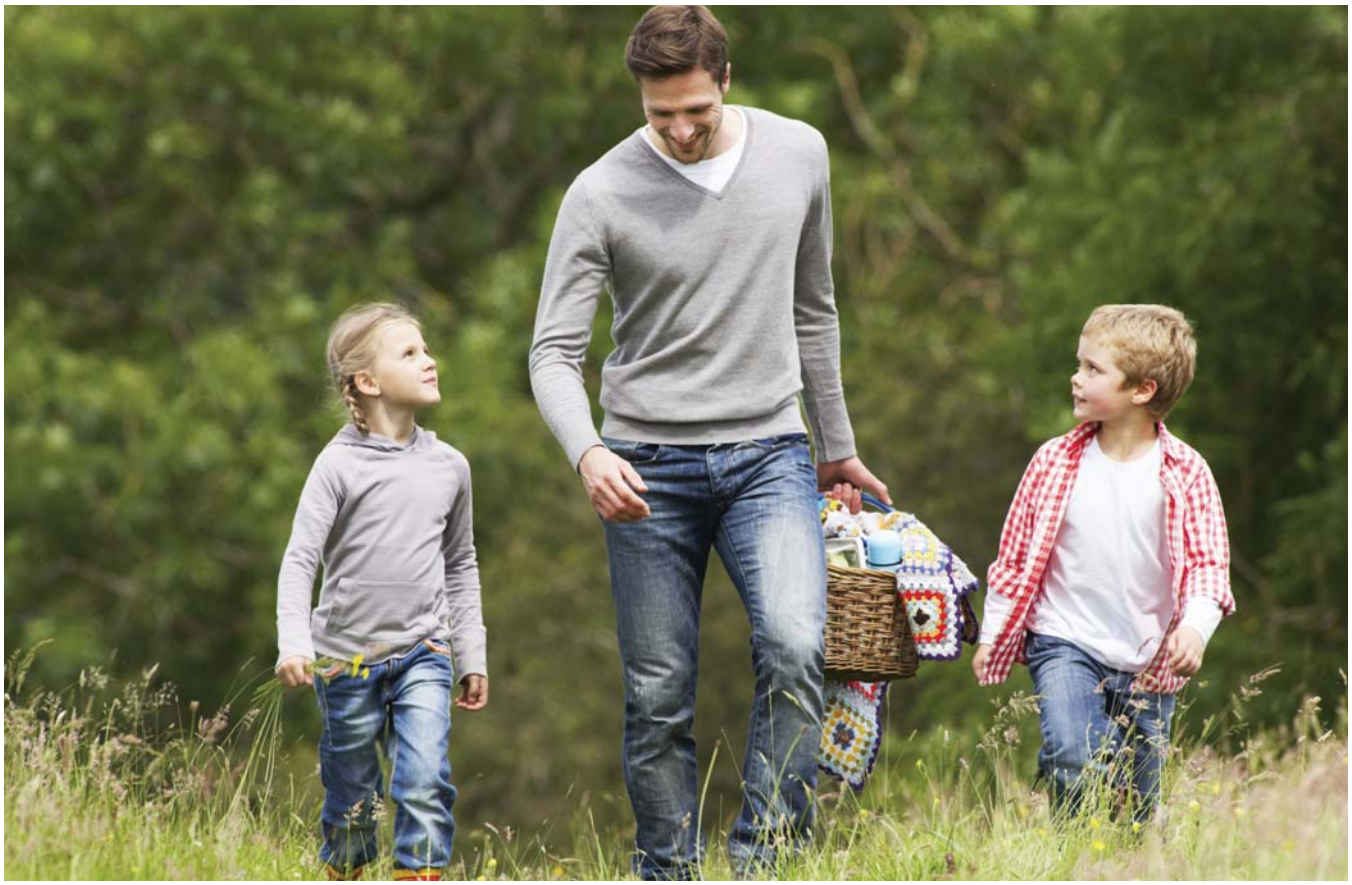
Financial Consultation

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.

DEFERRED COMPENSATION



Under the Federal Tax Laws, an employee of the Employer is subject to Federal Social Security Tax, unless the employee is a member of a retirement system (as defined by section 3121 (b)(7)(F) of the Internal Revenue Code) sponsored by the Employer. It is intended that the Plan constitute a retirement system for this purpose, and that accordingly, compensation paid by the Employer to employees covered by the Plan be exempt from Federal Social Security Taxes.

The Plan is intended to be an eligible, deferred compensation plan under section 457(b) of the Internal Revenue Code. The plan provides for deferral of payments of a portion of the participant's current compensation until death, retirement, or termination of employment in accordance with the provisions of Section 53212-53214 of the Government Code of the State of California, and Section 457 and other applicable sections of the Internal Revenue Code.

City Contribution – The City will contribute 3.75% of each participating employee's wages including overtime, "health and welfare premium", shift differential and "pool maintenance premium," to a deferred compensation plan administered by MassMutual Defined Contribution Services and referred to by the administrator as a "Guaranteed Account". Each participating employee will contribute an equivalent of 3.75% of "wages", as that term is described above.

IMPORTANT NOTICES

Newborns and Mothers Health Protection Act (NMHPA)

A health plan which provides benefits for pregnancy delivery generally may not restrict benefits for a covered pregnancy Hospital stay (for delivery) for a mother and her newborn 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 for this minimum length of stay and early discharge is only permitted 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)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prosthetics, and complications resulting from a mastectomy, including lymphedema. For more information, you can review the Summary Plan Description.

Grievance / Appeals

You have a right to two levels of appeal with our carriers, and a right to a response within a reasonable amount of time. However, also know that if a claim is not submitted within a reasonable time, the carriers have a right to deny that claim. The California Department of Managed Health Care (DMHC) is responsible for regulating health care plans. If you have a grievance against your health plan, you should first telephone your health plan and use your plan's appeal process before contacting the DMHC. Please review each contract for specific procedures on how to submit an appeal to a claim. This does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency or that has not been satisfactorily resolved by your health plan, or that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for Independent Medical Review for an impartial review of medical decisions made by a health plan related to medical necessity, coverage decisions for treatments that are experimental in nature, and payment disputes for emergency or urgent medical services. The DMHC can be reached at 888.HMO.2219 (TDD 877.688.9891) or hmohelp.ca.gov.

COBRA Continuation Coverage

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation cover must pay for COBRA continuation coverage.

If you're an Employee, you'll 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.

IMPORTANT NOTICES (continued)

If you're the spouse of an Employee, you'll become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. The Employer must notify the Plan Administrator of the following Qualifying Events:

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

For all other Qualifying Events (e.g. divorce or legal separation of the Employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to Human Resources and Risk Benefits Unit.

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 furnished by U.S. mail, registered or certified, postage prepaid and properly addressed 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 the 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 on; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

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

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

IMPORTANT NOTICES (continued)

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 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 at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF 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.

OTHER OPTION 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, 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 HealthCare.gov.

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

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 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 later than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered 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 subsection that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate. Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description for more information.

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 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 for eligibility for such assistance.

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about the 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, you can contact KeenanDirect at 855.653.3626 or at KeenanDirect.com, or contact the Health Insurance Marketplace directly at HealthCare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace offers "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 the Marketplace begins November 1, 2015 to January 31, 2016.

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, or 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 9.5% of your household income for the year, then that

coverage is not Affordable. 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.

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.

PART B: EXCHANGE APPLICATION INFORMATION

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 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 KeenanDirect.com.

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 510.238.4749	
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) 510.238.7446	12. Email address dcarter@oaklandnet.com	

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

The City of Oakland 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.

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

Please see the Summary Plan Description for more information.

Keenan & Associates

Innovative Solutions. Enduring Principles.

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