City of Merced

Retiree Benefits Overview

Effective: 1/1/15 through 12/31/15

Contents

Eligibility Guidelines

The City of Merced offers eligible employees medical, dental and vision care coverage after retirement. The benefits program is designed to meet the specific individual and family needs of each eligible retiree.

Medical Insurance

Medical insurance will be effective upon the date of retirement for eligible retirees and their eligible dependent(s). The premium for eligible dependent(s) coverage shall be the responsibility of the retired employee. At the age of 65, the City's medical plan shall be secondary to Medicare hospital and medical coverage or any other benefit coverage available to the retired employee and eligible dependent(s).

Dental & Vision Insurance

An eligible employee who retires after August 1, 1998, shall be eligible to continue coverage under the City's dental and vision plans. The premium shall be the responsibility of the retired employee. At the age of 65, the City's dental and vision plans will no longer be available to the retired employee and eligible dependent(s).

These Benefits Are Effective January 1, 2015

The information in this brochure is a summary only of the benefits offered under the City of Merced's benefit program. Specific details and plan limitations are provided in your individual Evidence of Coverage (EOC), which is based on the official Plan Documents that may include policies, contracts and plan procedures. Please refer to your EOC or Summary Plan Description for details. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

Eligibility Guidelines

Adding and Removing Dependents

You are responsible for notifying Support Services (209) 388-7100 of any changes in your dependent status during the plan year (Divorce, Marriage, Birth or Adoption and adding or removing dependents). All Qualified Life Event changes must be made within 30 days from the date of the event. A copy of the marriage certificate or adoption paperwork may be required for this kind of change. Failure to submit notification in a timely manner may impact dependent eligibility for health care continuation under COBRA which may result in you incurring liability for medical expenses for the non-eligible dependents. All changes will be effective the first of the month following the qualifying event date.

All employees adding dependents may be required to submit documentation verifying eligibility of their covered dependents. The following chart is an easy guide to which form and documents may be submitted.

For further clarification, please contact the Support Services department, (209) 388-7100.

	Nothing Required	Marriage Certificate Required	Dependent Verification*	State of California Domestic Partner Registration Required
Employee only	x			
Employee & Spouse		x		
Employee & Domestic Partner				x
Employee & Child(ren)			x	
Employee, Spouse or Domestic Partner & Child(ren)		x	x	x

* Dependent verification includes birth certificate or a legal document stating legal guardianship of the dependent.

When You Can Make Changes to Your Benefits

Other than during the annual "open enrollment" period, you may not change your coverage/participation unless you experience a qualifying event.

Qualifying events include:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, dissolution of domestic partnership, and death of a spouse
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child
- Change in employment status, including the start or termination of employment by you, your spouse, or your dependent child
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring *coverage* for your child or dependent foster child
- An event that is a special enrollment event under HIPAA (the Health Insurance Portability and Accountability Act), including acquisition of a new dependent or spouse or loss of coverage under another health insurance policy or plan if the coverage is terminated because of:
    - Voluntary or involuntary termination of employment or reduction in hours of employment or death, divorce, or legal separation;
    - Termination of employer contributions toward the other coverage, OR if the other coverage was COBRA Continuation Coverage, exhaustion of the coverage

Important—making changes to your benefits during the year:

- You must make the changes within 30 days of the date the *event* (marriage, birth, etc.) occurs.

When Your Benefits Terminate

When Your Benefits Terminate

- Health insurance benefits will terminate on the last day of the month of the event of termination.
- When terminating, the retiree must have been covered at least one full day in the month to get coverage for that month.
- COBRA, if elected, will be effective the first of the month following date of termination.

Benefits during the Family and Medical Leave (FMLA) and California Family Rights Act (CFRA)

An employee taking family/medical leave will be allowed to continue participating in any health and welfare benefit plan in which he/she was enrolled before the first day of leave (for a maximum of 12 work-weeks) at the level and under the same conditions of coverage as if the employee had continued in employment for the duration of such leave. The City will continue to make the same premium contributions as if the employee had continued working. The continued participation in health benefits begins on the date leave first begins under the Family and Medical Leave Act (e.g. for pregnancy disability leaves) or under the Family and Medical Leave Act/CFRA (e.g. for all other family care and medical leaves).

In some instances, The City may recover premiums paid to maintain health coverage for you if you fail to return to work following pregnancy disability leave/FMLA leave.

An employee's use of family/medical leave will not result in the loss of any employment benefit that the employee earned before using family/medical leave.

All employees must notify Support Services at (209) 388-7100 as soon as possible for requesting FMLA for your own illness or for caring for a family member.

Medicare and the Active Worker

If you are an active employee and have reached the age of 65, you may be wondering about Medicare. You should receive an advisory notice from Medicare about 4 months before your 65th birthday for your initial enrollment period. Here is some information that you should know about your Medicare options when working beyond age 65:

- You must stay in the Group Health medical plan until you retire or are otherwise not eligible for the group plan.

- You have the option of enrolling in Medicare Part B (medical) coverage at your cost. If you do so, your Group Health medical plan remains your primary and Part B (which does have a fee involved) would coordinate as secondary coverage to your Group Health medical plan.

- When you reach age 65, you must complete the Group Health Certification of Medicare Status form to report either your enrollment in Medicare Part B or your deferment until retirement.

- Once you retire with Group Health Medical Plan, you must sign up for Part B with Medicare during the eight months following the month that your health plan coverage or employment ended (whichever is first), also known as the Special Enrollment Period.

- If you choose to defer Part B, please be aware that there may be a 10% federal surcharge added to the monthly premium for every 12 month period that you were qualified to sign up for Medicare but did not enroll.

- Upon retirement, you will be transferred to the Medicare plan, assuming that you meet other eligibility requirements.

For additional information on Medicare and your options, contact Support Services at (209) 388-7100 or go to www.medicare.gov.

Benefit Plan Contact Information

Below is a list of toll-free numbers you can call with questions about benefit coverage or available providers in your area. Each company's website provides access to provider information and additional programs available to you and your family.

Benefit Plan & Carrier	Member Services: (for claims, eligibility and benefit inquiries)	Website:
Medical Coverage: Anthem Blue Cross (EPO)	1-800-967-3015	www.anthem.com/ca
Prescription Drug Coverage: Express Scripts	1-800-711-0917	www.expresscripts.com
Dental Coverage: Delta Dental PPO	1-888-335-8227	www.deltadentalca.org
Vision Coverage: Vision Service Plan (VSP)	1-800-877-7195	www.vsp.com
City of Merced Insurance Department Andrew Guzman Rosa Winzer	 1-209-385-6979 1-209-385-6867	 guzmana@cityofmerced.org winzerr@cityofmerced.org

Medical Benefits

General Plan Information	Blue Cross EPO Core Benefit
Annual Deductible • Member • Family	 **$100** **$300**
Maximum Plan Year Copayment/Coinsurance • Member • Family	 **$1,500** **$3,000**
Lifetime Maximum Benefit	Unlimited
Hospital	**Inpatient - $100 / day for 1st 3 days** **Outpatient - $100 / admit**
Physician Office visits	**$20/visit**
Preventive Care	No Charge (deductible waived)
Diagnostic X-Ray and Lab	No Charge (deductible applies)
Emergency Room (facility only)	**$200** waived if admitted
Ambulance	$50
Durable Medical Equipment	**20% of Allowed Charge**
Speech / Physical Therapy / Occupational Therapy	**$20 (deductible applies)**
Mental Health	
Inpatient	**$100 / day for 1st 3 days**
Outpatient	**$20**
Prescription Drugs (*30-day supply*)	
Generic	**$7**
Formulary Brand Name	**$25**
Non-formulary	100% of the Express Scripts discounted price
Mail Order Program (*90-day supply*)	
Generic	**$14**
Formulary Brand Name	**$60**
Non-formulary	100% of the Express Scripts discounted price
Mandatory Retail Refill Allowance Program*	Yes

Note: This summary is for informational purpose only. It does not amend, extend, or alter the current policy in any way. In the event information in this summary differs from the Plan Document, the Plan Document will prevail.

* The Retail Refill Allowance (RRA) applies to maintenance prescriptions refilled at a Retail Pharmacy. If you choose to continue to fill your maintenance prescription at a retail pharmacy, at the 4th fill and beyond the Retail copay will increase to the Mail Order copay level for 30 day supply.

Dental Benefits

General Plan Information	Delta Dental Core Benefit
Non-PPO Annual Deductible	
Per Person	$25
Family	$75
Maximums	
Annual	$1,000
Lifetime Orthodontic	$1,000
Covered Services	
Diagnostic and Preventive	100%
Basic Benefits	100%
Major	100%
Orthodontia	100%

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Vision Benefits

General Plan Information	VSP – Choice Network Core Benefit
Exam	$25
Materials	**$25**
Frequency of Services	
• Exam	12 months
• Lenses *OR* Contacts	**24 months**
• Frames	**24 months**
Annual Allowances	
• Frames	$120
• Contacts in lieu of Frames	$120
NON-MEMBER DOCTOR	
Benefits: (amount reimbursed, less deductible)	
Vision Exam	Up to $45 Paid
Lenses (Pair)	
- Single Vision	Up to $30 Paid
- Bifocal	Up to $50 Paid
- Trifocal	Up to $65 Paid
- Lenticular	Up to $100 Paid
Frame	Up to $70 Paid
Contact Lenses (in lieu of other eyewear)	
- Medically Necessary	Up to $210 Paid
- Elective	Up to $105 Paid

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Required Federal Notices

Notice of Availability of HIPAA Privacy Notice

The federal Health Insurance Portability and Accountability Act (HIPAA) requires that we periodically remind you of your right to receive a copy of the Insurance Carriers' HIPAA Privacy Notices. You can request copies of the Privacy Notices by contacting the Human Resources Department or by contacting the insurance carriers directly.

Notice of Availability of HIPAA Privacy Notice

We are required by federal and state law to protect the privacy of your individually identifiable health information and other personal information. City of Merced is committed to maintaining and protecting the confidentiality of our employees' personal and sensitive information.

The Women's Health and Cancer Rights Act

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

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

These benefits are subject to the same deductible and co-payments applicable to other medical and surgical procedures provided under this plan. You can contact your health plan's Member Services for more information.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low Cost Health Coverage to Children and Families

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2014. Contact your State for more information on eligibility –

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low Cost Health Coverage to Children and Families

ALABAMA – Medicaid

Website: http://www.medicaid.alabama.gov

Phone: 1-855-692-5447

ALASKA – Medicaid

Website:
http://health.hss.state.ak.us/dpa/programs/medicaid/

Phone (Outside of Anchorage): 1-888-318-8890

Phone (Anchorage): 907-269-6529

ARIZONA – CHIP

Website: http://www.azahcccs.gov/applicants

Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

COLORADO – Medicaid

Medicaid Website: http://www.colorado.gov/

Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/

Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)

Phone: 1-800-869-1150

IDAHO – Medicaid

Medicaid Website:
http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx

Medicaid Phone: 1-800-926-2588

MONTANA – Medicaid

Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml

Phone: 1-800-694-3084

INDIANA – Medicaid

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

Phone: 1-800-889-9949

NEBRASKA – Medicaid

Website: www.ACCESSNebraska.ne.gov

Phone: 1-800-383-4278

IOWA – Medicaid

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

Phone: 1-888-346-9562

KANSAS – Medicaid

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

Phone: 1-800-792-4884

NEVADA – Medicaid

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

Medicaid Phone: 1-800-992-0900

KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP

Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

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

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

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

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

Important Notice from the City of Merced about your Prescription Drug Coverage and Medicare

Important Notice from the City About Your Prescription Drug Coverage and Medicare

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

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

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

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

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City coverage will not be affected. The City provided prescription plan is credible and Medicare eligible's are allowed to purchase additional prescription drug coverage through Medicare. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current City coverage, be aware that you and your dependents may not be able to get this coverage back.

Important Notice from the City of Merced about your Prescription Drug Coverage and Medicare

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

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

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

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

Contact the City's Support Services Department at (209) 388-7100.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage …

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	January 1, 2015
Name of Entity:	City of Merced
Contact:	Support Services Department
Address:	678 W 18th Street, Merced, CA 95340
Phone:	(209) 388-7100

Summary of Benefits and Coverage (SBC)

Patient Protection and Affordable Care Act (PPACA) Disclosure Statement

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 case of illness or injury.

Your plan offers a choice of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a 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. If you are not clear about any of the bolded terms used in the SBC, you can view the glossary on your carrier's website or call them for a copy.

For your medical plan through Anthem go to www.anthem.com/ca or call 1-800-967-3015

For your medical plan through Blue Shield go to www.blueshieldca.com or call -1-877-554-3091.

For your Pharmacy benefits through Express Scripts (formerly Medco) go to www.expressscripts.com or call 1-800-711-0917.

City of Merced

"Gateway to Yosemite"

Employee Benefits Brochure designed and developed by

Alliant EMPLOYEE BENEFITS

In conjunction with the City of Merced – October 6, 2014