2017

Employee Benefits Overview – City of Merced

Take a Closer Look

At the City of Merced, we believe that you, our employees, are our most important asset. Helping you and your families achieve and maintain good health - physical, emotional and financial- is the reason City of Merced offers you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts is provided at the back of this summary.

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.

Medicare Part D Notice:

If you (and/or your dependents) 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. Please see the Annual Notices for more details.

The benefits in this summary are effective:

January 1, 2017 - December 31, 2017

Table of Contents

Revised September 26, 2016

For Assistance

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website	Policy/Group #
Medical	Anthem Blue Cross	(800) 333-0912	www.anthem.com/ca/EIAHealth	Core: 175075M529 Buy-Up: 175075M521
Pharmacy	Express Scripts	(800) 711-0917	www.express-scripts.com	Core: 175075M529 Buy-Up: 175075M521
Dental	Delta Dental	(888) 335-8227	www.deltadentalins.com	565
Vision	VSP	(800) 877-7195	www.vsp.com	12097042
Basic Life/ AD&D & Voluntary Life	Voya	(800) 955-7736	www.voya.com	31640-7/ Account 162
Short-Term & Long-Term Disability	Voya	(800) 877-5176	www.voya.com	31640-7/ Account 162
FSA	BCC	(800) 335-8227	www.benxcel.com	City of Merced
City of Merced's Insurance Department				
Rosa Winzer Phone	(209) 385-6867	Email: winzerr@cityofmerced.org		
Maggie Fuentes Phone	(209) 385-6979	Email: fuentesm@cityofmerced.org		

Information about City of Merced's Open Enrollment and Benefit information can also be accessed on the Internet:

https://www.cityofmerced.org/depts/insurance/default.asp

Who Can You Cover?

WHO IS ELIGIBLE?

Bargaining unit employees working 40 or more hours per week are eligible for the benefits outlined in this overview.

You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse).
- Your domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit. Please review the affidavit carefully because it includes important information about the guidelines for adding, ending or changing your domestic partner. Any premiums for your domestic partner paid for by City of Merced are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- Your child(ren) includes your (natural, adopted, legal guardianship):
    - Under the age of 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Employees who work less than 30 hours per week, temporary employees, contract employees, or employees residing outside the United States (unless otherwise qualified under the Affordable Care Act regulations).

WHEN CAN I ENROLL?

Coverage for new employees begins upon your date of hire.

Open enrollment for employees is generally held in October of each year. Open enrollment is the only time each year that employees can make changes to their benefit elections without a qualifying life event.

Make sure to notify Support Services Department right away if you have a qualifying life event and need to make a change (add or drop) to your coverage election. These changes include (but are not limited to):

- Birth or adoption of a baby or child (31 days)
- Loss of other healthcare coverage (31 days)
- Marriage/Domestic Partnership (31 days)
- Divorce/Termination of Domestic Partnership (31 days)

Please refer to Page 20 for further information.

Making the Most of Your Benefits Program

Helping you and your family members stay healthy and making sure you use your benefits program to its best advantage is our goal in offering this program. Here are a few things to keep in mind.

STAY WELL!

Harder than it sounds, of course, but many health problems are avoidable. Take action—from eating well, to getting enough exercise and sleep. Taking care of yourself takes care of a lot of potential problems.

ASK QUESTIONS AND STAY INFORMED

Know and understand your options before you decide on a course of treatment. Informed patients get better care. Ask for a second opinion if you're at all concerned.

GET A PRIMARY CARE PROVIDER

Having a relationship with a PCP gives you a trusted person who knows your unique situation when you're having a health issue. Visit your PCP or clinic for non-emergency healthcare.

USING THE EMERGENCY ROOM

Did you know most ER visits are unnecessary? Use them only in a true emergency—like any situation where life, limb, and vision are threatened. Otherwise, call your doctor, your nurse line, or go to an Urgent Care clinic. You'll save a lot of money and time.

AN APPLE A DAY

Eating moderately and well really does help keep the doctor away. Stay away from fat-heavy, processed foods and instead focus on whole grains, vegetables, and lean meats to be the healthiest you can be.

TAKE YOUR MEDICATION!

Always follow your doctor's and pharmacist's instructions when taking medications. You can worsen your condition(s) by not taking your medication or by skipping doses. If your medication is making you feel worse, contact your doctor.

GOING TO THE DOCTOR?

To get the most out of your doctor visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of what you want to talk about with your doctor

If you need a medication, you could save money by asking your doctor if there are generics or generic alternatives for your specific medication.

LiveHealth Online (LHO) Service

Have a health question? Under the weather? With LiveHealth Online, you don't have to schedule an appointment, drive to the doctor's office, and then wait for your appointment. In fact, you don't even have to leave your home or office. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed.*

With LiveHealth Online, you get:

- Immediate doctor visits through live video.
- Your choice of U.S. board-certified doctors.
- Subject to deductible, office copays, and coinsurance.
- Private, secure and convenient online visits.

Start a conversation now.

Just enroll for free at **livehealthonline.com** or on the app, and you're ready to see a doctor.

Medical

Medical coverage provides you with benefits that help keep you healthy like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition. The City of Merced provides health insurance through Anthem Blue Cross EPO Plans.

Anthem Blue Cross	**Core Benefits** **In-Network**	**Buy-Up Option** **In-Network**
Annual Deductible	$100/Individual $300/Family	None/Individual None/Family
Annual Out-of-Pocket Max	$1,600 (Individual) $3,300 (Family)	$1,000 (Individual) $2,000 (Family)
Lifetime Max	Unlimited	Unlimited
Office Visit **Primary Provider** **Specialist**	 $20 copay $20 copay	 $10 copay $10 copay
Preventive Services	Plan pays 100% (deductible waived)	Plan pays 100% (deductible waived)
Chiropractic Care	$5 Copay (limited 30 visits per calendar year)	$5 Copay (limited 30 visits per calendar year)
Lab & X-Ray	Plan pays 100% after the deductible	Plan pays 100%
Inpatient Hospitalization	$100/ day for the 1st three days (per occurrence)	Plan pays 100%
Outpatient Surgery	$100 per admit	Plan pays 100%
Speech/Physical Therapy/ Occupational Therapy	$20 copay after deductible	$10 copay
Emergency Room	$200 copay (waived if admitted)	$100 copay (waived if admitted)

Anthem Blue Cross Claims Address
P.O. Box 60007
Los Angeles, CA 90060-007

Customer Service:
(800) 967-3015

Hours: 8:30 a.m. to 4:15 a.m. Monday-Friday

Website:
www.anthem.com/ca/EIAHealth/

Anthem Mobile App

- Search for providers, hospitals and urgent care
- View, email or fax your ID card
- Secure and protected access

Download Instructions

- Go to the app store on your smartphone or mobile device
- Search for Anthem Blue Cross
- Select the app and start the free download
    - To use the application you must be registered on the Anthem secure member site and have a username and password

Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure.

If you enroll in medical coverage, you will automatically receive coverage for prescription drugs. Here are the prescription drug plans that are offered in conjunction with our Anthem Blue Cross EPO plans.

EXPRESS SCRIPTS®	**Core Benefits** **In-Network Only**	**Buy-Up Option** **In-Network**
Prescription Drug Deductible	N/A	N/A
Annual Out-of-Pocket Limit	$5,000/Individual $9,900/Family	$5,600/Individual $11,200/Family
Pharmacy Generic	$7 copay	$10 copay
Preferred Brand	$25 copay	$20 copay
Non-preferred Brand*	Member pays 100% of Express Scripts discounted price	Member pays 100% of Express Scripts discounted price
Supply Limit	30 days	30 days
Mail Order		
Generic	$14 copay	$20 copay
Preferred Brand	$60 copay	$50 copay
Non-preferred Brand* Supply Limit	100% of Express Scripts discounted price 90 days	100% of Express Scripts discounted price 90 days

*If you purchase a brand-name medication when a generic medication is available, you will pay the generic copayment, plus the difference in cost between the brand and the generic.

Note: After **three purchases** of a long-term prescription (such as those used to treat high cholesterol, high blood pressure, depression or diabetes) at a participating retail pharmacy, **your co-payment may increase**.

An App That Drives Better Decisions and Healthier Outcomes for Members on the Go

Prescription Drugs

If you need a medication on a long-term basis, you'll save money by using your mail-order pharmacy, instead of a drugstore. Express Scripts will deliver up to a 90-day supply of your medication right to you–and **standard shipping is free.**

***Retail fill allowance*:** The first two times that you purchase a long-term drug at a participating retail pharmacy, you'll pay your retail co-payment. After the second purchase, you'll pay a higher cost if you continue to purchase at retail. To avoid paying more, use the Express Scripts Pharmacy and pay your mail-order co-payment for up to a 90-day supply. That means you'll pay less over time. Your medications will be delivered right to you, and standard shipping is free. Once you get started, you can request refills easily by mail, online or over the phone.

Saving with generics

If you're taking a brand-name drug, talk to your doctor and ask whether a less expensive generic drug could treat your condition. If your doctor agrees, ask your doctor to write a new prescription for the generic that you can fill under your plan. FDA-approved generics are as safe and effective as their brand-name counterparts.

Saving with mail

Ask your doctor to write a new prescription for your plan's maximum days' supply (usually 90 days) with refills up to 1 year, as appropriate. You may mail your prescriptions in the special envelope you receive with your enrollment materials or ask your doctor to call 1 (888) 327-9791 for instructions on how to fax them. If your order is faxed, your doctor must have your member number to complete the transaction.

Express Scripts member services

Once enrolled you may call Express Scripts Member Services at (800) 711-0917, 24 hours a day, 7 days a week (except Thanksgiving and Christmas) for more details on your plan.

EXPRESS SCRIPTS®

Prescription Drugs

As your prescription drug benefit manager, Express Scripts wants to remind you of an important plan feature that affects your co-payment for long-term medications.

After **three purchases** of a long-term prescription (such as those used to treat high cholesterol, high blood pressure, depression or diabetes) at a participating retail pharmacy, **your co-payment may increase. ***

However, if you order your long-term prescriptions by mail from Express Scripts Pharmacy, you'll pay your mail-order co-payment for up to a 90-day supply.

*The medications affected by this plan limit may change. To find whether other medications are affected by these plan limits, visit www.express-scripts.com and select "Price a medication" from the left hand menu after you log in. After selecting your medication, click "coverage notes" on the results page. If you are a first-time visitor to our website, please take a moment to register and have your member ID number and a recent prescription number handy. If the cost of a medication at a retail pharmacy is lower than you plan's retail co-payment, you will not pay more than the retail pharmacy's cash price, regardless of the number of time you purchase the medication. In some cases, this price may be less than either you standard retail or mail co-payment.

For short-term medication: You should continue to get all your *short-term* drugs, such as antibiotics, at a participating retail pharmacy. You'll pay your retail pharmacy co-payment for these medications.

Before you send your first mail-order prescription, please make sure you have a 2-week supply of medication on hand while waiting for your new medication to arrive. If necessary, ask your doctor for a 14-day prescription that you can fill at a participating retail pharmacy.

You can transfer your long-term retail prescriptions to mail by going to www.express-scripts.com. Upon log in, scroll down the Order Page to the "Transfer you retail prescriptions to mail service" to select the medications you'd like to transfer to Express Scripts. We'll do the rest.

To learn more about how to use Home Delivery Services from Express Scripts Pharmacy

- **Go to www.express-scripts.com**
- **Call the number on the back of your prescription drug ID card 24 hours a day, 7 days a week**

EXPRESS SCRIPTS®

Dental Insurance

Save money with a Delta Dental PPO dentist. Our PPO network dentists accept reduced fees for covered services they provide you, so you'll usually pay the least when you visit a PPO network dentist. This also ensures Delta Dental PPO dentists won't balance bill you the difference between the contracted amount and their usual fee.

DELTA DENTAL	Delta Dental (Core Benefit)		Delta Dental (Buy-Up Option)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible	$25 Individual $75 Family	$25 Individual $75 Family	$25 Individual $75 Family	$25 Individual $75 Family
Maximum Annual Benefit (per member)	$1,000	$1,000	$1,500	$1,500
Preventative Services (deductible waived) **Oral Exam(s)** **Cleaning (2x per year)** **Sealants** **Fluoride treatment**	100% *of a **PPO** dentist fees*	100% *of **UCR***	100% *of a **PPO** dentist fees*	100% *of **UCR***
Basic Services **Amalgam Fillings** **Most Extractions** **Oral Surgery** **Endodontics** **Periodontics**	100% *of a **PPO** dentist fees*	100% *of **UCR***	100% *of a **PPO** dentist fees*	100% *of **UCR***
Major Services **Bridgework** **Dentures** **Crowns**	100% *of a **PPO** dentist fees*	100% *of **UCR***	100% *of a **PPO** dentist fees*	100% *of **UCR***
Orthodontia	100% of a **PPO** dentist fees	100% of **UCR**	100% of a **PPO** dentist fees	100% of **UCR**
Covered for Adults & Child(ren)	$1,000 Lifetime Maximum	$1,000 Lifetime Maximum	$1,500 Lifetime Maximum	$1,500 Lifetime Maximum

*Definition of UCR: Usual, Customary, Reasonable – Fees paid according to geographic location

Vision

Routine vision exams are important, not only for correcting vision, but because they can detect other serious health conditions.

VSP provides participants with access to a large network of vision care providers. To locate a network provider visit www.vsp.com. If you decide not to see a VSP doctor, the plan co-pay still applies. This choice is yours—either way, your VSP benefits are a tremendous part of your overall benefits package. There are no ID cards necessary for this plan

	VSP-Choice Network (Core Benefits)		VSP-Choice Networks (Buy-Up Option)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Examination	$25 Copay	Up to $45	$25 Copay	Up to $45
Benefit Frequency	Every 12 Months	Every 12 Months	Every 12 Months	Every 12 Months
Eyeglass Lenses				
Single Vision Lens	$25 Copay	Up to $30	Combined with Exam	Up to $30
Bifocal Lens	$25 Copay	Up to $50	Combined with Exam	Up to $50
Trifocal Lens	$25 Copay	Up to $65	Combined with Exam	Up to $65
Benefit Frequency	Every 24 Months	Every 24 Months	Every 12 Months	Every 12 Months
Frames (amounts reimbursed, less deductible)	$120 Allowance + 20% Off the Amount Over the Allowance	Up to $70	$120 Allowance + 20% Off the Amount Over the Allowance	Up to $70
Benefit Frequency	Every 24 Months	Once every 24 Months, In Lieu of Eyeglasses	Once every 12 Months, In Lieu of Eyeglasses	Once every 12 Months, In Lieu of Eyeglasses
Contacts (Elective)	$120 Allowance	Up to $105	$120 Allowance	Up to $105
Benefit Frequency	Once every 24 Months, In Lieu of Eyeglasses	Once every 24 Months, In Lieu of Eyeglasses	Once every 12 Months, In Lieu of Eyeglasses	Once every 12 Months, In Lieu of Eyeglasses

Notes/Comments: Vision benefits are based on a 12 month service year, not a calendar year. This means that you are not eligible for another exam, new lenses, frames or contacts until at least 12/24 months (Core) or 12/12 months (Buy-Up) have passed since you received services.

*When you choose contacts instead of glasses, your $120 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts.

Life Insurance - VOYA

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security. City of Merced currently provides Basic Life and Accidental Death and Dismemberment (AD&D) insurance as follows:

LIFE AND AD&D (Core Benefit)

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. Coverage is provided by Voya.

Basic Life Amount	1 x covered annual earnings up to a maximum of $50,000
Basic AD&D Amount	1 x covered annual earnings up to a maximum of $50,000
Guarantee Issue Amount	1 x covered annual earnings up to a maximum of $50,000

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

SUPPLEMENTAL LIFE AND AD&D (Buy-Up Option)

Supplemental Life Insurance allows you to purchase additional life insurance to protect your family's financial security. All Active employees under the age of 80 are eligible. Coverage is provided by Voya.

Employee Benefit:

Buy-Up Life Amount	5 x covered annual earnings up to a maximum of $100,000
Election Options	$10,000; $20,000; $40,000; $50,000; $60,000; $80,000; $100,000
Guarantee Issue Amount	$100,000
Employees over Age 70	Maximum benefit is $50,000

Spouse Benefit:

Buy-Up Life Amount	Up to $50,000
Election Options	$5,000; $10,000; $20,000; $30,000; $40,000; $50,000
Guarantee Issue Amount	$50,000

Dependent Child(ren) Benefit:

Birth to 14 Days	$0
14 Days to 6 Months	$250 (14 Days to 6 Months)
6 Months to 19 Years (to 25 yrs. if FT Student)	$10,000
Guarantee Issue Amount	$10,000

Disability Insurance - VOYA (White Collar Employees)

The City of Merced offers an integrated disability plan that is designed to be simpler and more cost effective for employees. This feature includes a **Short-Term Disability** plan which allows for weekly payments during your initial disability period up to 22 weeks (180 days). If your disability exceeds 22 weeks (180 days), your payments will convert to a **Long-Term Disability** plan and you will receive monthly payments for the duration of your disability per contract definitions. If you continue to be disabled, you are automatically assigned a **Long-Term Disability** benefit. Coverage is provided by Voya.

SHORT-TERM DISABILITY INSURANCE (STD)

STD Plan:	**Core Benefit**	**Buy-Up Option**
Weekly Benefit Amount	Plan pays 60% of covered monthly earnings	Plan pays 66.67% of covered monthly earnings
Maximum Weekly Benefit	**$600/ week**	**$1,650/ week**
Benefits Begin After:		
Accident	30 days of disability	30 days of disability
Sickness	30 days of disability	30 days of disability
Maximum Payment Period*	22 Weeks (White Collar)	22 Weeks (White Collar)

*Maximum payment period is based on the first day you are disabled, not when benefits begin.

LONG-TERM DISABILITY INSURANCE (LTD)

Plan:	**Core Benefit**	**Buy-Up Option**
Monthly Benefit Amount	Plan pays 60% of covered monthly earnings	Plan pays 66.67% of covered monthly earnings
Maximum Monthly Benefit	**$2,500**	**$7,000**
Benefits Begin After:		
Accident	180 days of disability	180 days of disability
Sickness	180 days of disability	180 days of disability
Maximum Payment Period*	**To Age 65 or SSNRA**	**To Age 65 or SSNRA**

Core Disability Benefits

1. The Short-Term Disability plan starts after the elimination period has been satisfied and, the exhaustion of leave accruals, pays a weekly benefit of 60% of your weekly salary to a maximum of $600 a week. The duration of the Short Term Disability benefit is 22 weeks (180 days), minus the elimination period.

2. The Long-Term Disability benefit is paid on a monthly basis and covers up to 60% of your monthly salary up to a maximum of $2,500 a month. The duration of the Long Term Disability benefit is to age 65 or your normal social security retirement age as long as you meet the definition of disability

Buy-Up Disability Benefits

As an employee, you will also have the opportunity to purchase additional benefits:

3. STD Buy-up to 66.67% of your weekly salary to a maximum of $1,650 a week. The duration of the Short Term Disability benefit is 22 weeks (180 days), minus the elimination period and exhaustion of leave accruals.

4. Buy-up to 66.67% of your monthly salary up to a maximum of $7,000 a month. The duration of the Long Term Disability benefit is to age 65 or your normal social security retirement age as long as you meet the definition of disability.

If you are interested in purchasing the "Buy-Up" Disability benefits, please see Support Services.

Disability Insurance (All Other Active Employees)

The City of Merced offers an integrated disability plan that is designed to be simpler and more cost effective for employees. This feature includes a **Short-Term Disability** plan which allows for weekly payments during your initial disability period up to18 weeks (126 days). If your disability exceeds 18 weeks (126 days), your payments will convert to a **Long-Term Disability** plan and you will receive monthly payments for the duration of your disability per contract definitions. If you continue to be disabled, you are automatically assigned a **Long-Term Disability** benefit. Coverage is provided by Voya.

SHORT-TERM DISABILITY INSURANCE (STD)

STD Eligibility: All Other Active Employees (Excluding White Collar Employees)

STD Plan:	**Core Benefit**	**Buy-Up Option**
Weekly Benefit Amount	Plan pays 60% of covered monthly earnings	Plan pays 66.67% of covered monthly earnings
Maximum Weekly Benefit	**$600/ week**	**$1,650/ week**
Benefits Begin After:		
Accident	60 days of disability	60 days of disability
Sickness	60 days of disability	60 days of disability
Maximum Payment Period*	18 Weeks (All Other Employees)	18 Weeks (All Other Employees)

*Maximum payment period is based on the first day you are disabled, not when benefits begin.

LONG-TERM DISABILITY INSURANCE (LTD)

Plan:	**Core Benefit**	**Buy-Up Option**
Monthly Benefit Amount	Plan pays 60% of covered monthly earnings	Plan pays 66.67% of covered monthly earnings
Maximum Monthly Benefit	**$2,500**	**$7,000**
Benefits Begin After:		
Accident	180 days of disability	180 days of disability
Sickness	180 days of disability	180 days of disability
Maximum Payment Period*	**To Age 65 or SSNRA**	**To Age 65 or SSNRA**

Core Disability Benefits

1. The Short-Term Disability plan starts after the elimination period has been satisfied, and the exhaustion of leave accruals, and pays a weekly benefit of 60% of your weekly salary to a maximum of $600 a week. The duration of the Short Term Disability benefit is 18 weeks (126 days), minus the elimination period.

2. The Long-Term Disability benefit is paid on a monthly basis and covers up to 60% of your monthly salary up to a maximum of $2,500 a month. The duration of the Long Term Disability benefit is to age 65 or your normal social security retirement age as long as you meet the definition of disability.

Buy-Up Disability Benefits

As an employee, you will also have the opportunity to purchase additional benefits:

3. STD Buy-up to 66.67% of your weekly salary to a maximum of $1,650 a week. The duration of the Short Term Disability benefit is 18 weeks (126 days), minus the elimination period and exhaustion of leave accruals.

4. LTD Buy-up to 66.67% of your monthly salary up to a maximum of $7,000 a month. The duration of the Long Term Disability benefit is to age 65 or your normal social security retirement age as long as you meet the definition of disability.

If you are interested in purchasing the "Buy-Up" Disability benefits, please see Support Services.

Flexible Spending Account (FSA)

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. The catch is that you have to use the money in your account by our plan year's end. Otherwise, that money is lost, so plan carefully. You must re-enroll in this program each year. Benefit Coordinators Corporation (BCC) administers this program.

IMPORTANT CONSIDERATIONS

- Expenses must be incurred between 01/01/17 and 12/31/17 and submitted for reimbursement no later than 03/31/18.
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- Unused amounts will be lost at the end of the plan year, so it is very important that you plan carefully before making your election.
- FSA funds can be used for you, your spouse, and your tax dependents only.
- You can obtain reimbursement for eligible expenses incurred by your spouse or tax dependent children, even if they are not covered on the City of Merced health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).
- Keep your receipts. In most cases, you'll need to provide proof that your expenses were considered eligible for IRS purposes.

HEALTHCARE FSA ACCOUNT

This plan allows you to pay for eligible out-of-pocket healthcare expenses with pre-tax dollars. Eligible expenses include medical, dental, or vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. You may access your entire annual election from the first day of the plan year and you can set aside up to $2,500 this year.

DEPENDENT CARE FSA ACCOUNT

This plan allows you to pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. Eligible expenses may include daycare centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are considered your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can set aside up to $5,000 per household for eligible dependent care expenses for the year.

Your
Flexible Spending Account
with BCC

Benefit Coordinators Corporation (BCC) is your employer's Flexible Spending Account (FSA) Administrator. BCC brings a number of important assets to the partnership, including a staff of experienced professionals, state-of-the-art technology and unrivaled customer service. The result is a seamless administrative system that yields high employee satisfaction. Current participant maximums under the Plan are $2,500 for the Health Care FSA and $5,000 for the Dependent Care FSA.

Information for Participants

Fast and Easy Claim Processing – BCC provides first-rate FSA claims processing. Your claim form, along with valid substantiation, can be submitted to BCC via mail, fax, secure download or e-mail. Your claim will then be processed within two to five business days of receipt and reimbursed every two weeks.

Mail claims to: Benefit Coordinators Corporation,
Attn: FSA Claims Two Robinson Plaza, Suite 200
Pittsburgh, PA 15205-1324

· Fax claims to: (412) 276-7185
· Securely download claims to:
http://secure.benXcel.com
· E-mail claims to: fsa-claims@benXcel.com

Online Account Access - You can check the entire history of your FSA pledge, including all contributions and benefit payments, online by logging in to www.BenXcel.com and clicking 'Reimbursement Accounts' in the left frame. Your account information is available 24/7 and claims are shown on BenXcel® 48-72 hours upon receipt.

Convenience at your Fingertips – You can also access your account status 24/7 over the phone with BCC's telephone Interactive Voice Response (IVR) system. Just call the toll-free, automated IVR number – (800) 685-6100 for instant information. By calling, you get accurate account balances and access to current claims-payment data.

Direct Deposit – You may have your FSA reimbursements deposited directly into your checking or savings account by simply completing the authorization form available from your HR Department. These transactions will be reflected on the explanation of benefits (EOB).

FSA Benefits Debit Card Convenience - The FSA benefits card has made spending your FSA funds on eligible expenses easier than ever! The card allows you to avoid out-of-pocket expenses, cumbersome paperwork, and reimbursement delays. Swiping your FSA benefits card at the point of service deducts the payment directly from your account, giving you instant access to your FSA dollars. It can be used at all eligible FSA locations where Mastercard® is accepted. One card can manage multiple account types, such as a Health Care Account, Dependent Care Account. The My SmartCare online portal and mobile app support the use of this benefits card by separating each of your account types for fast and easy review of all your FSA funds in one place.

Customer Service – When you need FSA answers, just call BCC's Customer Service Center toll-free at **(800) 685-6100**. Dedicated representatives are available Monday through Friday from 8:00am to 7:00 pm EST.

Supplies & More Information– At any time, you can download additional forms and BCC's informative FSA brochures and FAQs at www.BenXcel.com. All of these materials can be found in the 'Forms and Brochures' section in the left frame of BCC's main webpage.

Key Terms

MEDICAL/GENERAL TERMS	
Allowable Charge	The negotiated amount that in-network providers have agreed to accept as full payment.
Balance Billing	A practice where out-of-network providers bill a member for charges that exceed the plan's allowable charge.
Coinsurance	The percentage cost share between the insurance carrier and a member.
Copay	The dollar amount a member must pay directly to a provider at the time of service.
Explanation of Benefits (EOB)	The statement you receive from the insurance carrier that details how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay your provider until you have received this except for copays.
Family Deductible	The maximum dollar amount any one family will pay out in individual deductibles in a year.
Individual Deductible	The dollar amount a member must pay each year before the plan will pay benefits for certain services.
In-Network	Services received from providers (doctors, hospitals, etc.) who have agreed to limit their fees for health plan members to a negotiated allowable charge.
Out-of-Network	Services received from providers (doctors, hospitals, etc.) who have not agreed to limit their fees to a negotiated allowable charge. Out-of-network benefits are usually lower and additional balance billing charges will apply whenever the provider charges more than the plan's allowable charge.
Out-of-Pocket Maximum	That maximum amount that you will pay each year for covered services.
Preventive Care	A routine exam - usually yearly that may include a physical exam, immunizations and tests for cancer.
PRESCRIPTION DRUG TERMS	
Brand Prescription Drug	A drug which is produced and distributed under patent protection with a trademarked name from a single drug manufacturer. A generic drug may be available if the patent has expired.
Dispense as Written (DAW)	A prescription that does not allow for substitution of an equivalent generic or similar brand drug.
Maintenance Medications	Medications taken on a regular basis for an ongoing condition. Examples of maintenance medications include oral contraceptives, blood pressure medication and asthma medications.
Non-Preferred Brand Drug	A brand drug for which alternatives are available from either the insurance carrier's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.
Preferred Brand Drug	A brand drug that an insurance carrier has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of their

	clinical effectiveness and their cost.
Specialty Pharmacy	Provide special drugs that are used to treat complex conditions such as multiple sclerosis, cancer and HIV/AIDS.
Step Therapy	The practice of beginning drug therapy for a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

DENTAL TERMS	
Basic Services	Basic services generally include coverage for fillings and oral surgery.
Diagnostic and Preventive Services	Diagnostic and preventive services generally include services such as routine cleanings, oral exams, x-rays, sealants and fluoride treatments. Most plans limit the frequency of preventive exams and cleanings to two times a year.
Endodontics	Commonly known as root canal therapy.
Implants	Dental implants are surgically implanted replacements for the natural tooth root of missing teeth. Many dental plans do not cover implants.
Major Services	Generally include coverage for restorative dental work such as crowns, bridges, dentures, inlays and onlays.
Orthodontia	A benefit that is offered under some dental plans. It generally includes services for the treatment of alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.
Periodontics	The diagnosis and treatment of gum disease.
Pre-Treatment Estimate	An estimate that the insurance company provides detailing how much they will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

Required Federal Notices

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 may not enroll in a Medicare Supplemental 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, you must sign up for Part B with Medicare during the eight months following the month that your group 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 related benefit options, contact the City of Merced's Support Services Department or go to www.medicare.gov.

Required Federal Notices

Notice of Availability of HIPAA 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 City of Merced at 678 W 18th Street, Merced, CA 95340.

HIPAA Notice of Special Enrollment Rights for Medical/Health Plan Coverage

If you decline enrollment in the City of Merced's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, or you experience a Qualifying Life Event, you or your dependents may be able change your status in the City of Merced's health plan without waiting for the next open enrollment period.

The following "Qualifying Life Events" require you to notify the Support Services Department within 31 days after the event.

- **Lose other health insurance or group health plan coverage.**
- **Gain a new dependent as a result of marriage/domestic partnership, birth or adoption.**
- **Loss of a dependent as a result of death, divorce/termination of domestic partnership, end of the child's status as a dependent, placement for adoption or subscriber is entitled to Medicare.**

If you lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, you must request medical plan enrollment within 60 days after the loss of such coverage.

If a court has ordered that coverage be provided for a dependent child, coverage will become effective for that child on the earlier of (a) the first day of the month following the date you file the enrollment application or (b) within 30 days after a copy of the court order is received or of a request from the district attorney, either parent or the person having custody of the child, or the employer.

If you request a change due to a special enrollment event within the appropriate timeframe, 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, except for court orders. In addition, you may enroll in the City's 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 eligibility for medical plan 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. Please refer to the Carrier Benefit Booklet for further details.

Required Federal Notices

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires employer groups to notify participants and beneficiaries of the group health plan, of their rights to mastectomy benefits under the plan. Participants and beneficiaries have rights for coverage to be provided in a manner determined in consultation with the attending Physician 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). If you would like more information on maternity benefits, call your plan administrator.

Michelle's Law Notice

Extended dependent medical coverage during student medical leaves. The City of Merced plans may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason. Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required. If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, Contact the City of Merced as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

Notice of Grandfathered Health Plans

The City of Merced believes that some coverage maybe "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that your CSAC Excess Insurance Authority (EIA) plans may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. 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 do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Required Federal Notices

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 **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 **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 **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, 2015. Contact your State for more information on eligibility—

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
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	**NEW YORK – Medicaid**

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS - Medicaid and CHIP	**NORTHCAROLINA- Medicaid**
Website:http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website:http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA - Medicaid	**NORTH DAKOTA - Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-657-3739	Phone: 1-800-755-2604
MISSOURI - Medicaid	**OKLAHOMA- Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website:http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA - Medicaid	**OREGON- Medicaid**
Website:http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website:http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA - Medicaid	**PENNSYLVANIA- Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone:	Website:http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA - Medicaid	**RHODE ISLAND - Medicaid**

Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300
SOUTH CAROLINA - Medicaid	**VIRGINIA - Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON - Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/Pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS- Medicaid	**WEST VIRGINIA - Medicaid**
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
UTAH - Medicaid and CHIP	**WISCONSIN - Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT- Medicaid	**WYOMING - Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	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, 2016, 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)

Required Federal Notices

Medicare Part D Notice

Important Notice from City of Merced About

Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Merced 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:

1. 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.

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your City of Merced coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Anthem Blue Cross is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

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

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

You should also know that if you drop or lose your current coverage with City of Merced 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 October to join.

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

Contact City of Merced listed below for further information. 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 City of Merced 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 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 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.**

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

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

Date:	**January 1, 2017**
Name of Entity/Sender:	**City of Merced**
Contact:	**Support Services Department**
Address:	**678 W 18th Street, Merced, CA 95340**
Phone Number:	**(209) 388-7100**

Notes

City of Merced

"Gateway to Yosemite"