2024 BENEFITS

01/01/2024 – 12/31/2024

We’ve got you covered!

San Ramon

7000 Bollinger Canyon Road
San Ramon, CA 94583

Caring For You. Caring For Our Community.

At the City of San Ramon, 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 the City of San Ramon offers you this comprehensive benefits program. We are providing you with this guide 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 guide.

While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or Summary Plan Descriptions (SPDs). These documents determine how all benefits are paid. This guide is not intended to be a contract (expressed or implied), nor is it intended to otherwise create any legally enforceable obligations on the part of the City, its agents, or its employees.

The City of San Ramon recognizes that your benefits are an important part of the reason you choose to work here. The City provides a variety of high-quality benefits largely paid for by the City or at a reasonable cost to you. You can also choose between different optional benefits to meet your individual and family needs.

Since you have some choices to make, it is important to understand the various programs. That is why this guide is being provided for you. There are also individual brochures for each of the benefit plans available in the Human Resources Division. Benefits provided by the City for eligible employees include a retirement plan, medical plans, a dental plan, a vision plan, group life insurance, disability coverage, an employee assistance plan, and Lasik Eye Surgery benefits. Benefited employees may also elect to participate in these additional voluntary options:

- 457 Deferred Compensation & Roth Plan
- Flexible Spending Accounts (Medical and Dependent Care)
- Adoption Assistance
- Commuter Benefits (Parking and Transit)
- Supplemental/Voluntary Life Insurance

If you have any questions or need additional information, please contact Human Resources at (925) 973-2523

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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 page 31 for more details.

Open Enrollment

Coverage for newly eligible employees begins on the first day of the month following date of hire. New employees who do not make an election within 31 days of becoming eligible will automatically be enrolled for single coverage in the core medical plan.

Open enrollment is generally held from mid-September to mid-October. Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event. Make sure to notify the Human Resources Division 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):

- 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 qualifying life event under the Health Insurance Portability and Accountability Act (HIPAA), 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—Two rules apply to making changes to your benefits during the year:

- Any changes you make must be consistent with the change in status, AND
- You must make the changes within 31 days (60 days for CalPERS medical plans) of the date the event (marriage, birth, etc.) occurs.

Who Can You Cover?

WHO IS ELIGIBLE?

All employees whose contracts qualify them for benefits are eligible for benefits. You can enroll the following family members in the City's 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 a State of California Domestic Partner (DP) Registration. Any premiums for your domestic partner paid for by City of San Ramon 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 children** (including your domestic partner's children or children of another person can as long as a parent-child relationship exists between the employee and child. A parent-child relationship must be reviewed and certified by affidavit.)

    - 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.

Please refer to the Summary Plan Description of each plan for complete details on how benefits eligibility is determined.

WHO IS NOT ELIGIBLE?

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

- Parents, grandparents, grandchildren, and siblings (unless certified by Parent-Child Relationship Affidavit).
- Any individual who is covered as an employee of City of San Ramon cannot also be covered as a dependent.
- Temporary employees, contract employees, or employees residing outside of the United States, in accordance with the Affordable Care Act guidelines.

WHEN WILL MY BENEFITS TERMINATE?

Your medical benefits end on the first day of the second month following the date of separation or loss of eligibility. Your dental and vision plan coverage ends on the last day of the month following your date of separation or loss of eligibility. Your Flexible Spending Accounts (FSA), Group Life/AD&D, Short Term Disability (STD), Long Term Disability (LTD), and Employee Assistance Program (EAP) coverage ends on the date of your termination.

You may be eligible to continue benefits for a limited period of time after termination or during a leave of absence according to federal guidelines and in conjunction with City policy, under your federal and state COBRA rights.

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. Group health insurance coverage will be continued in the same manner for up to 17 ⅓ weeks for employees disabled due to pregnancy, childbirth, or a related medical condition. 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 or under the California Family Rights Act.

Note: For further information on Family and Medical Leave, please refer to the City of San Ramon's FMLA policy located on the intranet.

All employees must notify Human Resources at (925) 973-2523 as soon as possible regarding FMLA for your own serious health condition or that of a family member.

Dependent Eligibility Verification

All employees adding/removing dependents must submit documentation to verify their dependent's eligibility and/or Qualifying Life Event. The following chart is an easy guide to what documents must be submitted along with the Health Enrollment/Change form.

- Dependent children verification includes birth or adoption certificate and social security number.
- Only provide first page of your prior year FEDERAL Tax Return that shows your dependents and black out any monetary amounts. STATE Tax Returns are not acceptable.
- Proof of marriage must be a state issued marriage license or marriage certificate (not a church issued certificate) that includes the date of your marriage.
- State Registration Certificate is required for Domestic Partnership.
- Affidavit of Parent-Child Relationship is required for eligible Parent-Child relationships.
- Birth Certificates must be state issued (not hospital issued).

	Nothing Required	Marriage Certificate	Birth Certificate/ Certificate of Adoption	State of California Domestic Partner (DP) Registration	Economically/ Disabled Dependent Child Affidavit and Federal Tax Return
Employee only	•				
Employee & Spouse		•			
Employee & Children			•		
Employee & Parent-Child Relationship or Disabled Children			•		•
Employee, Spouse & Children		•	•		
Employee, Spouse & Parent-Child Relationship or Disabled Children		•	•		•
Employee and DP				•	
Employee, DP and Children			•	•	
Employee, DP & Parent-Child Relationship or Disabled Children			•	•	•

You are responsible for ensuring that the health enrollment information about you and your family members is accurate, and for reporting any changes in a timely manner. If you fail to maintain current and accurate health enrollment information, you may be liable for the reimbursement of health premiums or health care services incurred during the entire ineligibility period.

Cash In-Lieu of Medical and/or Dental Coverage

Employees who have minimum essential medical coverage and/or dental coverage through another source (other than coverage in the individual market, whether or not obtained through Covered California) may elect to waive enrollment in the City's medical and/or dental plan(s).

Those satisfying the City's requirements may be eligible for a monthly cash in-lieu payment. The employee must provide proof of other group coverage in order to participate. The proof of other coverage must show that the employee and all individuals in the employees expected tax family have (or will have) minimum essential coverage. Proof of other coverage must be provided every plan year. The cash in-lieu amounts are as follows:

SEIU LOCAL 1021 AND UNREPRESENTED MISCELLANEOUS EMPLOYEES

	Medical Only	Dental Only	Medical and Dental
Employee Only	$300.00	$50.00	$350.00
Employee + 1	$400.00	$75.00	$475.00
Employee + 2 or more	$500.00	$100.00	$600.00

POLICE OFFICER'S ASSOCIATION (POA) EMPLOYEES

	Medical Only	Dental Only	Medical and Dental
Employee Only	$510.71	$50.00	$560.71
Employee + 1	$1,021.41	$75.00	$1,096.41
Employee + 2 or more	$1,327.84	$100.00	$1,427.84

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.

BE MED WISE!

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?

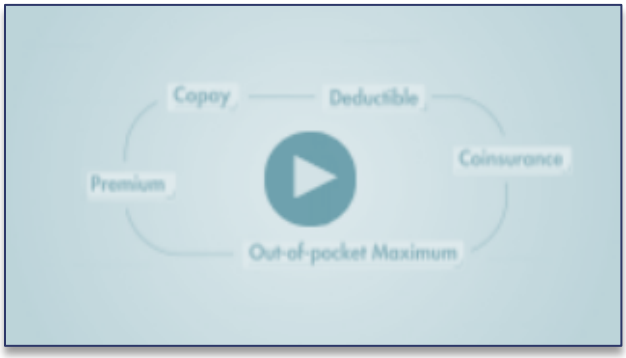
To get the most out of your doctor visit, being organized and having a plan helps. Bring the following with you:

- 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.

KEY TERMS

Click here to watch the video below to learn about some key terms related to your medical plans.



Medical Benefits

Click here to view your CalPERS Health Plans/Rates!

It is the City's goal to provide you with affordable, quality health care benefits. Our medical benefits are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. The City offers a choice of medical plans through CalPERS Medical. When making a selection for a health plan, please keep in mind that the City aligns its contribution rates with the CalPERS Kaiser Region 1 premium. The City contribution rates for the 2024 calendar year are as follows:

Employee Only	$ 1,021.41
Employee & 1 Dependent	$ 2,042.82
Employee & 2+ Dependents	$ 2,655.67

HEALTH MAINTENANCE ORGANIZATION (HMO)

Under HMO plans, most services and medicines are covered with a small copayment. Most HMOs require you to select a Primary Care Physician (PCP) to coordinate your care and require advance approval for some services, such as treatment by a specialist.

Care must generally be obtained from in-network providers, or you may be required to pay out of pocket for the cost of services (except in the event of emergency or urgent care services). Not all HMO plans are available in all California counties. To see if these plans are available in your zip code, visit the CalPERS website at www.calpers.ca.gov and use the zip code finder search engine.

PREFERRED PROVIDER ORGANIZATION (PPO)

PPO plans are designed to provide choice, flexibility, and value. A PPO plan is a managed care organization of medical doctors, hospitals, and other health care providers who have contracted with your insurer to provide health care at reduced rates to you. Participants have a choice of using network providers or going directly to any other physician (non-network provider) without a referral.

For most services, there is an annual deductible to meet before benefits apply. You are also responsible for a certain percentage of the charges (coinsurance), and the plan pays the balance up to the agreed upon amount. Non-network providers are typically covered at a lower benefit level requiring you to pay a higher percentage of the bill.

CALPERS SEARCH TOOLS

CalPERS Health Plan Search by Zip Code

To find CalPERS health plans available in your area, search by zip code at www.calpers.ca.gov

Why Would I Choose the PPO Plan?	Why Would I Not Choose the PPO Plan?
• You have a doctor you like, and you would like to keep this doctor. • You want to see specialists and other providers without having to first get a referral and/or pre-approval. • You want the freedom to see providers who are not in the network. • You are confident that you can manage your own care. • You do not want a primary care doctor.	• You don't want the extra responsibility of managing your own care. • PPOs are not as closely regulated by the government as HMOs. • You do not want to pay the higher costs of a PPO. • You do not want to get bills from providers.

EXPLORE YOUR BENEFITS WITH MYCALPERS

Access your health information year-round, including available health plans and Open Enrollment updates, by logging in to myCalPERS at https://my.calpers.ca.gov.

Cost of Coverage

MEDICAL VIA CALPERS

2024 CalPERS Region 1 Medical Plans	Plan Premiums			Monthly Cost to Employees		
	Employee Only	Employee & 1 Dependent	Employee & 2+ Dependents	Employee Only	Employee & 1 Dependent	Employee & 2+ Dependents
Anthem HMO Select	$1,138.86	$2,277.72	$2,961.04	$117.45	$234.90	$305.37
Anthem HMO Traditional	$1,339.70	$2,679.40	$3,483.22	$318.29	$636.58	$827.55
Blue Shield Access+ *(Only available in select counties)*	$1,076.84	$2,153.68	$2,799.78	$55.43	$110.86	$144.11
Blue Shield EPO *(Only available in select counties)*	$1,076.84	$2,153.68	$2,799.78	$55.43	$110.86	$144.11
Blue Shield Trio *(Only available in select counties)*	$946.84	$1,893.68	$2,461.78	$0.00	$0.00	$0.00
Kaiser CA	$1,021.41	$2,042.82	$2,655.67	$0.00	$0.00	$0.00
PERS Gold	$914.82	$1,829.64	$2,378.53	$0.00	$0.00	$0.00
PERS Platinum	$1,314.27	$2,628.54	$3,417.10	$292.86	$585.72	$761.43
PORAC	$931.00	$2,117.00	$2,651.00	$0.00	$74.18	$0.00
United Healthcare Alliance	$1,091.13	$2,182.26	$2,836.94	$69.72	$139.44	$181.27
United Healthcare Harmony *(Only available in select counties)*	$937.39	$1,874.78	$2,437.21	$0.00	$0.00	$0.00
Western Health Advantage *(Only available in select counties)*	$807.23	$1,614.46	$2,098.80	$0.00	$0.00	$0.00

DENTAL – POA

	Total Cost	Your Cost
Employee Only	$58.80	$0.00
Employee + 1 Dependent	$102.20	$0.00
Employee + 2 Dependents	$169.70	$0.00

DENTAL – SEIU / UNREPRESENTED

	Total Cost	Your Cost
Employee Only	$63.40	$0.00
Employee + 1 Dependent	$110.50	$0.00
Employee + 2 Dependents	$183.80	$0.00

VISION

	Total Cost	Your Cost
Employee Only	$5.62	$0.00
Employee + 1 Dependent	$10.86	$0.00
Employee + 2 Dependents	$17.25	$0.00

Dental – Delta Dental

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

Go PPO

Visit a PPO dentist to maximize your savings. These dentists have agreed to reduce fees, and you won't get charged more than your expected share of the bill. Premier dentists' contracted fees are usually higher than PPO dentists.

Check-in with Ease

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your plan, they will need your name, birth date and enrollee or social security number. Prefer to take a paper or electronic ID card with you? Simply sign in to www.deltadentalins.com, where you can view or print your card with the click of a button. If you're covered under two plans, ask your dental office about the coordination of benefits.

	DELTA DENTAL PPO PLAN *SEIU & Unrepresented – Annual Plan Max of $2,500* *POA – Annual Cap of $1,800*		
	Delta PPO Dentist	**Delta Premier Dentist** Reimbursement is based on PPO contracted fees for PPO dentists	**Non-Delta Dentist** Reimbursement is based on PPO contracted fees for PPO dentists
Calendar Year Deductible	$25 $75	$25 $75	$25 $75
Annual Plan Maximum	**POA**: $1,900 **SEIU & Unrepresented**: $2,500	**POA**: $1,800 **SEIU & Unrepresented**: $2,500	**POA**: $1,800 **SEIU & Unrepresented**: $2,500
Waiting Period	None	None	None
Diagnostic and Preventive	Plan pays 100%	Plan pays 100%	Plan pays 100%
Basic Services			
Fillings	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 90% after deductible
Root Canals	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 90% after deductible
Periodontics	Plan pays 90% after deductible	Plan pays 90% after deductible	Plan pays 90% after deductible
Major Services	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Orthodontic Services			
Orthodontia	Plan pays 50%	Plan pays 50%	Plan pays 50%
Lifetime Maximum	$1,800	$1,800	$1,800
Adults and Dependent Children	Covered	Covered	Covered

Vision – Vision Service Plan (VSP)

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions. VSP now covers standard progressive lenses in full.

VSP Exclusive Member Extras

- Enjoy Low Prices on Hearing Aids with TruHearing
- High Quality Vision Care
- Choice of Providers
- Great Eyewear
- Eyeconic – Use out-of-network allowances to shop designer frames plus the most popular contacts at eyeconic.com the online eyewear store for VSP members
- Direct Pay Convenience – It's simple to use your VSP benefits at Walmart and Sam's Club. Simply say, "I have VSP"

	VSP VISION PLAN	
	In-Network	**Out-Of-Network**
Examination		
Benefit	Plan pays 100%	Up to $45
Frequency	1 x every 12 months	In-network limitations apply
Materials	Plan pays 100%	Plan pays 100% (see schedule below)
Eyeglass Lenses		
Single Vision Lens	plan pays 100% of basic lens	Up to $30
Bifocal Lens	plan pays 100% of basic lens	Up to $50
Trifocal Lens	plan pays 100% of basic lens	Up to $65
Frequency	1 x every 12 months	In-network limitations apply
Frames		
Benefit	Up to $130 plan pays (20% off amount over $130)	Up to $70
Frequency	1 x every 24 months	In-network limitations apply
Contacts (Elective)		
Benefit	Up to $180 (instead of eyeglasses)	Up to $105
Frequency	1 x every 12 months	In-network limitations apply

Lasik Eye Surgery Reimbursement — The City will also reimburse 50%, up to $1,500, of Lasik Surgery expenses for you and your eligible dependents. Please contact Human Resources for additional information.

Member Extras – VSP and Delta Dental

VSP TRUHEARING

VSP Vision Care members can save up to 60% on the latest brand name hearing aids. Dependents and even extended family members are eligible for exclusive savings, too! Hearing loss is growing in the workplace.

Like vision loss, hearing loss can have a huge impact on productivity and overall quality of life. Unfortunately, of the over 38 million people who need hearing aids, only one in five has them. And the high cost of hearing aids is a major factor keeping people from addressing their hearing loss.

TruHearing also provides members with:

- Three provider visits for fitting and adjustments
- A 45-day trial
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement
- 48 free batteries per hearing aid

Plus, members get:

- Access to a national network of more than 3,800 hearing healthcare providers
- Straight-forward, nationally fixed pricing on a wide selection of the latest brand-name hearing aids
- Deep discounts on batteries shipped directly to their door

Best of all, if your organization already offers a hearing aid benefit, members can combine it with TruHearing prices to reduce their out-of-pocket expense even more!

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or, call (877) 396-7194 with questions.

DELTA DENTAL QUALSIGHT LASIK

Because Delta Dental has selected QualSight to offer you access to discounts on LASIK services. Through QualSight, you can save 40-50% off the national average price of Traditional LASIK along with big savings on Custom and Custom Bladeless LASIK procedures!

You get preferred pricing on LASIK through QualSight providers across the nation. Plus, pre- and postoperative visits are included, along with a one-year assurance plan. There's no need to fear — QualSight's network is built with credentialed laser eye surgeons who have collectively performed more than 6.5 million procedures. With more than 1,000 LASIK locations4, you can choose the physician with the experience, reputation and technology your vision correction requires.

Give a QualSight a call at **(855) 248-2020** and a care manager will explain the program and answer any questions. When you're ready, pick a physician and pay a discounted price for LASIK services. **To learn more, visit www.qualsight.com/-delta-dental**.

Life Insurance –Voya

The City offers Basic Life Insurance and Accidental Death and Dismemberment Insurance (AD&D) at no cost to you. **You also have the option to elect additional coverage called Supplemental Life Insurance.**

WHY DO I NEED LIFE INSURANCE?

Below are a few examples of how your life insurance benefit could be used (coverage amounts may vary):

- Pay off any remaining medical bills, funeral costs and debts
- Provide ongoing financial support to your family
- Keep your family in your home by paying off the mortgage
- Fund your children's education

WHO IS ELIGIBLE FOR LIFE INSURANCE?

- **You—**all regular, full-time employees
- **Your spouse—under age 70**. If your spouse is covered under the policy as an employee, then your spouse is not eligible for coverage under the spouse rider/benefit. Coverage is available only if Employee Supplemental Life Insurance is elected.
- **Your children—to age 26**. Coverage is available only if Employee Supplemental Life Insurance is elected. If both you and your spouse are covered under the policy as employees, then only one, but not both, may cover the same children under the children's rider/benefit. If the parent who is covering the children stops being insured as an employee, then the other parent may apply for children's coverage.

WHAT AMOUNT OF COVERAGE AM I ELIGIBLE FOR?

- **For you—**Your employer provides you with Basic Life Insurance and Basic AD&D Insurance of two times your annual salary to a maximum of $500,000 for all eligible POA Employees, SEIU Local 1021 Employees, Other Eligible Miscellaneous Employees and $600,000 for City Manager. There is no cost to you for this insurance. Coverage amounts are rounded to the next higher $1,000. Eligible employees may elect Supplemental Group Term Life Insurance of $20,000 to $500,000 in $10,000 increments. Supplemental AD&D Insurance is also available in an amount equal to your approved Employee Supplemental Life Insurance up to $500,000.
- **For your spouse**— Eligible employees may elect Spouse Supplemental Life Insurance of $10,000 to $250,000 in $5,000 increments. Coverage is limited to 100% of the total amount of employee Supplemental Life Insurance.
- **Spouse Supplemental AD&D Insurance** is also available in an amount equal to the approved Spouse Supplemental Life Insurance, up to $250,000.
- **For your children—**Eligible employees may elect Children Supplemental Life Insurance of $2,500, $5,000, $7,500 or $10,000.

DO I NEED TO PROVIDE EVIDENCE OF INSURABILITY TO BE COVERED?

New Hires

- **For you** – you may elect up to $150,000 without providing Evidence of Insurability (health questionnaire).
- **For your spouse** – you may elect up to $50,000 of Supplemental Life Insurance on your spouse without providing Evidence of Insurability.
- **For your children** – You may elect up to $10,000 of Supplemental Life Insurance on your children without providing Evidence of Insurability.
- If you elect higher amount(s), you will need to submit Evidence of Insurability for approval before coverage becomes effective.

Current Employees

If you did not elect Supplemental Life Insurance when initially eligible (new hire), then you will be required to provide Evidence of Insurability for any elected amount

Life Insurance – Voya

HOW MUCH DOES SUPPLEMENTAL LIFE INSURANCE COST?

Basic Life Insurance and Basic AD&D Insurance is provided by the City at no cost to you.

The cost for Supplemental Life is calculated based on the age of the employee or spouse at the start of the plan year (January 1).

Life Benefit	Employee	Spouse	Dependent Child
Minimum	$20,000	$10,000	Choice of: $2,500, $5,000, $7,500 or $10,000
Maximum	$500,000	$250,000	Choice of: $2,500, $5,000, $7,500 or $10,000
Increments Of	$10,000	$5,000	Choice of: $2,500, $5,000, $7,500 or $10,000
Guaranteed Issue*	$150,000	$50,000	$10,000

* Guaranteed Issue only applies to new employees. Existing employees do not have a guaranteed issue amount.

Employee and Spouse Age	Monthly Rate per $1,000 of Coverage
Under 25	$0.060
25-29	$0.060
30-34	$0.075
35-39	$0.098
40-44	$0.143
45-49	$0.210
50-54	$0.360
55-59	$0.600
60-64	$0.915
65-69	$1.763
70 +	$2.865
Dependent Child Rate	$0.21

SUPPLEMENTAL AD&D Rate

Employee/Spouse (per $1,000): $0.04

Disability Insurance for SEIU Local 1021 and Miscellaneous Employees – Voya

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability coverage pays you a benefit if you temporarily can't work because of an injury, illness, or maternity leave. Your doctor and the insurance company will work together to determine how long benefits are payable, based on your condition. Coverage is provided by Voya Financial.

Weekly Benefit Amount	Plan pays 66.67% of covered weekly earnings
Maximum Weekly Benefit	$2,310
Benefit Waiting Period*:	
Accidental Injury	30 days of disability
Sickness	30 days of disability
Maximum Benefit Period	9 weeks

*The benefit waiting period begins on the first day you see a doctor and he or she states in writing that you are disabled because of sickness or accidental injury.

LONG-TERM DISABILITY INSURANCE

Long-Term Disability coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long time. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security.

If you qualify, long-term disability benefits begin after short-term disability benefits end. Coverage is provided by Voya Financial.

Monthly Benefit Amount	plan pays 66.67% of covered monthly earnings
Maximum Monthly Benefit	$10,000
Benefits Begin After:	
Accidental Injury	90 days of disability
Sickness	90 days of disability
Maximum Benefit Period*	SSNRA

*The age at which the disability begins may affect the duration of the benefits.

Long Term Disability Insurance for Sworn Only

CALIFORNIA LAW ENFORCEMENT ASSOCIATION
SAN RAMON POLICE OFFICERS
ASSOCIATION GROUP LONG TERM DISABILITY PLAN A

Monthly Cost	$27.00 per month, level cost payroll deduction
Percentage of Wages Protected*	85% of wages Non-Industrial Disability 70% of wages Industrial Disability (100% of wages for Catastrophic Disabilities for up to 30 months – not to exceed maximum monthly benefit) (No Workers' Compensation Permanent Disability offsets) Maximum Benefit of $10,000 per month, tax-free
Waiting Period	30 Calendar days – If less than 60 days of personal leave, you may receive 70% of wages after 30 days. Otherwise, 60 calendar days.
Benefit Period	Lifetime: Sickness, Accident and Pregnancy (Industrial Disability and Non-Industrial Disabilities)
Freeze or Personal Leave Option	After 60 calendar days
Personal Leave Integration Benefit	After 60 calendar days, you may use personal leave and receive a supplemental benefit from the Plan up to the Maximum Percentage or use 100% personal leave and receive $1,000 per month ($100 per month for Industrial or Disputed Workers' Comp.)
Cost of Living Benefit (COLA)	4% compounded per year (years 3-8) thereafter, CPI increase to age 65 and then continued lifetime benefits
Return to Work Incentive Benefit	$1,800 per month for Non-Industrial Catastrophic Total Disability if a Participant returns to gainful employment.
Waiver of Payment	Waiver of Payment after no-pay status
Benefits Payable During Challenged Workers' Compensation Cases	After 60 calendar days – 70% of wages to a Maximum Benefit of $10,000 per month (Repayable only if settled in your favor)
Stress & Psychological Conditions	18 months maximum benefit amount 3 months per occurrence. Must return to work for 1 year between each occurrence. No limit if hospitalized.
Minimum Monthly Benefit	$1,000 per month – paid in addition to personal leave after 60 calendar days. ($100 for Industrial or Disputed Workers Compensation Claims.)
Death Benefit	$65,000 Death Benefit on or off duty, natural, accidental, or terminal illness $15,000 initial benefit then $1,000 per month for 50 months $10,000 for suicide ($2,000 first 2 years in plan**) $20,000 Military Active Service Benefit Benefits may be payable within 24 hours of notification
Survivorship Benefit	Six (6) months additional benefits to dependent beneficiary
Pre-Existing Medical Condition Coverage	If you enroll during your initial enrollment period, all pre-existing medical conditions will be covered once you have been in the Plan for 24/48*** months. Unless you are eligible for the Prior Coverage Credit – otherwise pre-existing medical conditions will not be covered.
Ownership of Plan	Operated managed and funded by its Participants through a representative Board of Directors (non-profit California Corporation since 1985)

*Maximum percentages reflect amount payable after completion of (a) waiting period, (b) freeze of personal leave option, or (c) personal leave integration. Offsetting Benefit/Income Amounts are applied to reduce amount from the Plan.
**The Death Benefit for suicide is limited to $2,000 for the first 24 months of participation in the Plan.
***Forty-eight months for Death Benefits and for HIV, AIDS, and ARC.

Life Enhancements – Voya

LIFE BENEFIT EXTRAS

As an added value to your life insurance plan, Voya offers a counseling and referral service to City of San Ramon employees through ComPsych. (Note: This is separate from the Magellan Employee Assistance Program.)

The Employee Assistance Program (EAP) benefit offered through ComPsych includes confidential counseling for you and your dependents at no charge as well as the following services:

- **Employee Assistance**: FamilySorce®, a work-life and personal convenience service.
- **Legal Services**: Your GuidanceResources benefit includes a free, 30-minute consultation with a local network attorney, plus a 25 percent reduction in the attorney's customary legal fees thereafter.
- **Estate Planning Services**: Log on to EstateGuidance to complete a customized will for your estate, utilize an intelligent online questionnaire to guide you through the process, name a guardian for your children, name an executor(s) to settle your estate, specify funeral and burial wishes, make revisions at no cost for up to 30 days.
- **Financial Benefit**: In-house staff includes Certified Public Accountants (CPAs), Certified Financial Planners (CFPs) and other professionals who are exclusively dedicated to providing financial information by phone.
- **Travel Assistance Benefit**: The Travel Assistance program through Voya provides important travel assistance services when you or your covered dependents are 100 miles or more from home, whether domestic or international. (See next page for more information).
- **Funeral Concierge Benefit**: Everest, a funeral planning and concierge service, can be used to plan a funeral for an employee; a spouse or domestic partner; or an employee's dependents up to age 26. For more information on this benefit, call (800) 913-8318 or visit www.everestfuneral.com/voya

To access these benefits, contact ComPsych at (877) 533-2363 or visit www.guidanceresources.com and use Web ID MY5848i to register. When prompted, enter the first five (5) characters of the company code CITY (followed by a space).

Travel Assistance – Voya

SECURITY WHEN YOU TRAVEL

We live in a highly connected world where frequent domestic and international travel is the norm. Voya Travel Assistance offers you enhanced security for your leisure and business trips. You and your dependent will have toll-free or collect-call access to the Voya Travel Assistance customer service center or access to the services provided on the website 24 hours a day, 365 days a year—from anywhere in the world.

COVERED SERVICES

When traveling more than 100 miles from home, Voya Travel Assistance offers you and your dependents four types of services: Pre-Trip Information, Emergency Personal Services, Medical Assistance Services, and Emergency Transportation Services.

Pre-Trip Information—These valuable services help you start your trip the right way. Voya Travel Assistance can provide you with important, up-to-date travel information including:

- Immunization requirements
- Visa & passport requirements
- Foreign exchange rates
- Embassy/consular referral
- Travel/tourist advisories
- Temperature & weather conditions
- Cultural information

Emergency Personal Services—In the event of an unexpected situation of a non-medical nature, Voya Travel Assistance offers access to several valuable services, including:

- Urgent message relay
- Interpretation/translation services
- Emergency travel arrangements
- Recovery of lost or stolen luggage or personal possessions
- Legal assistance and/or bail bond

Medical Assistance Services Include:

- Medical referrals for local physicians and dentists
- Medical case monitoring
- Prescription assistance and eyeglass replacement
- Arrangement and payment of emergency medical services (up to $10,000 with a written guarantee of reimbursement from the eligible participant).

Emergency Transportation Services—Should you need medical care or assistance while traveling, Voya Travel Assistance can help. When deemed medically necessary by a Voya Travel Assistance designated physician, evacuation and transportation to the nearest adequate medical facility that can properly treat your condition will be arranged and paid for on your behalf.

Flexible Spending Accounts – P&A Group

The Flexible Spending Accounts (FSA) are a great way to use pre-tax dollars to pay for expenses paid with after-tax dollars! You may enroll in either or both the **Medical Spending Account** or the **Dependent Care Spending Account**.

These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts. Money from these accounts is then used to pay eligible expenses that are not reimbursed by your health plans, as well as reimbursement for dependent care expenses.

Pre-tax means the dollars you allocate toward these accounts are not subject to social security tax, Federal income tax and, in most cases, state and local taxes. The money you set aside may be used for qualified eligible expenses on a pre-tax basis.

At enrollment, you determine the amount of money to contribute to one or both of these accounts for the City's plan year. The contributions are deducted pre-tax per pay period from your paycheck and deposited into the FSA account(s). You request reimbursement of qualified expenses as you incur the expenses from your FSA account(s).

Please estimate your annual contributions carefully! There is a "Use it or Lose it" rule if you do not claim expenses incurred. Claims for expenses incurred by the end of February of the following plan year must be submitted by March 31st or you will lose the unexpended portion of your contributions.

At the beginning of every calendar year, the City contributes $500 to the Medical Spending Account for full-time regular employees. Those employees may combine their own dollars for maximum contribution to the Medical Spending Account.

The City also offers a **Commuter Benefit** that allows you to set aside pre-tax dollars for your public transportation needs such as riding BART or taking the bus!

Flexible Spending Accounts – P&A Group

MEDICAL SPENDING ACCOUNT

This account will reimburse you with pre-tax dollars for qualified out-of-pocket healthcare expenses not covered under your healthcare plan. Medical-related expenses include out of pocket money for copays or deductibles for medical, dental and vision services. A detailed listing of all qualified expenses is available on the P&A Group website at www.padmin.com.

The maximum amount you may contribute to the Medical Spending Account for the 2024 Plan Year is **$3,200** per person, per plan. There is no household maximum as with the Dependent Care Spending Account. Therefore, if your spouse's employer also offers an FSA, he/she could also enroll up to the maximum amount.

DEPENDENT CARE SPENDING ACCOUNT

The maximum amount you may contribute to the Dependent Care Spending Account is $5,000 each calendar year, or $2,500 each calendar year if you are married but file separate tax returns. This account will reimburse you with pre-tax dollars for eligible expenses for your child(ren) and other qualifying dependents. This covers the cost you pay to daycare centers, after-school programs, babysitters, caregivers, or elder care so that you and your spouse can work.

Qualifying individual is defined as any of the following:

- A person under the age of 13 who is your "qualifying child" under the Internal Revenue Code
- Your spouse if he or she is physically or mentally incapable of self-care and has the same abode as you for more than half the year
- A person who is physically or mentally incapable of self-care, has the same principal abode as you for more than half the year and is your tax dependent under the Code

COMMUTER BENEFIT ACCOUNT

The Parking and Transit Expense Reimbursement Plan enables you to avoid taxes on the money you use to pay for work-related parking or transit. Depending on your tax bracket, you could save up to 40% on state, federal and FICA taxes while contributing up to **$315** per month for parking and **$315** per month for transit expenses.

Estimate the money you expect to pay for parking or transit and have that dollar amount withheld from your paychecks pre-tax each month. The money you elect to be withheld from your paycheck is credited to an account in your name that is used to pay for your parking or transit expenses.

BENEFITS CARD/HOW TO SUBMIT A CLAIM

P&A Group will issue you a Benefits Card that works likes a debit card. When you incur an eligible expense, present your Benefits Card to the provider of the goods or services you are purchasing. Swipe your card at the point-of-service and the expense will automatically be deducted from your Flexible Spending Account balance. If you are unable to use your Benefits Card, you can still be reimbursed for all eligible expenses. You can submit a claim electronically or by mail. Log into your account at www.padmin.com to access more information.

P&A Group FSA

(800) 688-2611

Adoption Assistance FSA – P&A Group

The Adoption Assistance Account provides reimbursement to you for the reasonable and necessary expenses that you incur in the process of legally adopting an eligible child, including adoption fees, court costs, attorney fees and related travel costs. The City also provides a $5,000 adoption benefit for eligible employees, which reduces the amount you can defer into the account.

Expenses that are not eligible for reimbursement include expenses incurred in violation of state or federal law, expenses incurred in carrying out a surrogate parenting arrangement, and expenses in connection with the adoption of a stepchild. An "eligible child" is a child who has not yet reached age 18 or is physically or mentally incapable of caring for himself or herself. Also, the child must be younger than you and must be unmarried.

QUALIFIED ADOPTION EXPENSES

- Reasonable and necessary adoption fees
- Court Costs
- Attorney fees

FAQ'S

If I start the adoption process after Open Enrollment, do I have to wait for the next Open Enrollment to sign up for adoption assistance benefits?
No. You can make a special, mid-year election for adoption assistance benefits within 30 days after you start the adoption process.

What happens if I overestimate my adoption expenses and have money left over in my Adoption Assistance Account at the end of the plan?
The use-or-lose rule requires that any money that's left over after you've been reimbursed for all of your eligible expenses during a particular plan year must be forfeited. By law, the left-over money may not be carried forward into the next Plan Year. That's why any benefit election that you decide to make should be based strictly on expenses that you are certain to have during the Plan Year covered by the election.

What supporting information must I submit with my claims?
P&A must have evidence that you have started an adoption. This would be apparent if you submit a bill from an adoption agency or a document from a court indicating the nature of the judicial proceeding. Also, P&A must be able to see that expenses like travel costs are related to your adoption proceeding.

What happens if I make an election of adoption assistance benefits and then the adoption falls through?
If you had an adoption assistance election in effect for a particular Plan Year, and then the adoption was cancelled, you could stop your election including your payroll withholding contributions at that time. However, you would not be entitled to a refund of any money that remained in your adoption assistance account. You would forfeit that money.

Employee Assistance Program – Magellan

From simple questions like quick ways to de-stress or how to find more time in your schedule, to make difficult issues like finding support after the loss of a loved one, Employee Assistance Program (EAP) is there to work with you and offer suggestions, options, and information.

Your program includes up to 5 counseling sessions (per year) for you and your eligible dependents or household members at no cost to you.

A CONFIDENTIAL AND IMPORTANT RESOURCE

EAP provides useful tools and resources that can help make the most out of your day or guide you through a difficult time. All confidential and at no cost to you. Some of the topics EAP can help include:

- **Resiliency**- overcoming stress and crisis at home and at work
- **Emotional Wellness**- addiction, depression, anxiety, and assistance with other emotional wellness issues
- **Workplace success**- career goals, team conflict, crisis, management support
- **Wellness and balance**- work-life balance, stress, relaxation, personal well-being
- **Personal and family goals**- relationship, children and teen or aging loved ones. Changes in finances or personal situations

ADDITIONAL RESOURCES AND INFORMATION

Health and Wellness Program

Magellan makes it easy to bring healthy habits into your busy life. You can set daily goals and track progress online, via mobile app and through integration with fitness trackers. You can even get help and motivation from health coaches and peers.

Work-life Services

You have access to tools, resources and experts who can help with many of the day-to-day things that can happen in life. You also have access to the LifeMart® discount center which offers valuable discounts on things such as travel, clothing, restaurants, and more.

Legal and Financial Consultation

Magellan offers you quick and confidential access to help with legal or financial questions and services you may need. Legal and financial experts are available to help with any questions you may have or access the online library for helpful tools and resources.

Magellan Employee Assistance Program

(800) 424-4039

www.MagellanHealth.com/member

Deferred Compensation & Roth IRA Plan – MissionSquare

The City offers a 457 deferred compensation plan and a Roth IRA plan in which you may voluntarily participate. By signing a payroll deduction authorization, you can have the City withhold a certain portion of your salary (minimum of $10 each pay period) to a maximum established by law.

The maximum contribution amount for 457 and Roth IRA plans are $23,000 combined for employees under age 50, and $30,500 for employees over age 50. This money is invested in the program(s) you choose. Your investment is payable to you when you terminate or retire, or to your beneficiary in the event of your death. For more information, please visit: https://www.missionsq.org/plan-sponsors/plan-rules/contribution-limits.

The amount of your salary that has been withheld is the deferred amount and is not subject to taxes during your employment; however, the deferred compensation, to include interest and dividends earned as a result of the investment, is subject to taxes when it is actually received.

Loans from 457 plan - Participants are able to take loans from their 457 plans for anything from home purchase to debt consolidation.

Managed Accounts - For those employees who would like an added level of guidance, this program is designed to take over the day-to-day management of your deferred compensation account.

The City in no way guarantees the success of any investment program selected and is not liable for any losses that might be incurred under the Deferred Compensation program. For additional information, you may contact: MissionSquare Retirement Corporation at (800) 669-7400 or InvestorServices@icmarc.org.

ICMA-RC is now

MissionSquare RETIREMENT

Additional Employee Voluntary Benefits

The City offers the additional benefits listed below. For more information, please contact Human Resources at (925) 973-2523.

LASIK EYE SURGERY REIMBURSEMENT

The City of San Ramon offers a reimbursement of 50% (up to $1,500) for Lasik eye surgery for employees and their eligible dependents.

EMPLOYEE COMPUTER LOAN PROGRAM

The City of San Ramon encourages development of employee computer literacy skills, because of the acknowledged contributions those skills contribute to an improved public service. As such, the City has developed the Employee Computer Loan Program to provide a financing alternative for employees wishing to purchase personal computer hardware and software similar to what they may be asked to use for City business.

This program is available to regular, full-time, and part-time non-probationary employees of the City of San Ramon based upon the availability of funds and the appropriateness of the purchase based upon the employee's job duties. Additional information can be found on the City's intranet benefits page.

PACIFIC SERVICE CREDIT UNION

Pacific Service Credit Union offers credit union membership services to employees and family members through Pacific Service Credit Union. For more information, visit the San Ramon branch, or visit online at www.pacificservice.org.

DISCOUNT RECREATION PROGRAMS

Current regular employees of the City of San Ramon, their spouse or domestic partner, and their children under the age of 21 living in the household may receive a 20% discount for Recreation Activities (excluding theatre tickets, special event admissions, senior drop-in programs, adult sports leagues, daily recreation swim, and daily lap swim) and the Rental of Facilities offered by the Parks and Community Services Department. In addition, current regular employees of the City of San Ramon may use the Open Gym Programs and Aquatics Centers for daily drop-in Recreation and Lap Swim at no cost to the employee (family members are not eligible for this benefit). Employees must present their City badge to the Front Counter in order to enter the Facility at no charge. "Regular employees" are those employees hired into budgeted full-time or part-time positions and eligible for City benefits.

To sign up for this benefit, please email Mae Mlyniec, Administrative Analyst, for the Parks & Community Services Department at mmlyniec@sanramon.ca.gov.

EMPLOYEE TUITION REIMBURSEMENT PROGRAM

It is the policy of the City of San Ramon to encourage training, self-improvement and personal development programs for employees which includes limited financial aid in the form of tuition reimbursement for employees. The Tuition Reimbursement Program allows for reimbursement of tuition for job related courses taken. There is a $5,250 annual employee maximum, as well as a dollar threshold per course, based on the highest course rates between Cal State East Bay, San Jose State, and San Francisco State. To participate in the program, the policy requires a request to be submitted 60 days prior to the date the course begins. Participation will be considered on a first-come, first-serve basis as long as funding is available. See the City's Personnel Rules and Regulations for more details.

Report Workplace Wrongdoing

Harassment, discrimination, theft, violence, fraud, unsafe acts and other forms of wrongdoing hurt everyone. Now, you can help eliminate these problems. Report wrongdoing to your manager or supervisor or call the Employee Reporting Line Toll-Free at 1-877-651-3924 or go online at www.employeeprotectionline.com.

Identify your place of employment (City)

Entity Organization Code: 10070

The Employee Reporting Line is monitored 24 hours a day by an independent third party. You can make your report without disclosing your identity and calls and online reports will not be traced.

Benefit Provider Contact Information

Plan Type	Provider	Phone Number	Website
CalPERS Medical	CalPERS Medical & Retirement	(888) 225-7377	www.calpers.ca.gov
	Anthem	(855) 839-4524	www.anthem.com/ca/calpers/hmo
	Blue Shield of CA	(800) 334-5847	www.blueshieldca.com/calpers
	Kaiser Permanente	(800) 464-4000	my.kp.org/calpers/
	Western Health	(888) 942-7377	www.westernhealth.com/calpers
	United Healthcare	(877) 359-3714	https://www.whyuhc.com/calpers
	PORAC	(800) 288-6928	www.porac.org
	PERS PPO	(877) 737-7776	www.anthem.com/ca/calpers
Dental	Delta Dental #18125-00001 (POA) #18125-00002 (Unrep/SEIU)	(800) 765-6003	www.deltadentalins.com
Vision	VSP #12137687	(800) 877-7195	www.vsp.com
Flexible Spending Account	P&A Group	(800) 688-2611	www.padmin.com
Employee Assistance Program	Magellan	(800) 424-4039	www.magellanhealth.com/member
Life Insurance	Voya Policy: #316407 Acct: #177	(800) 955-7736	www.voya.com
Deferred Compensation	Mission Square (formerly ICMA)	(800) 669-7400	https://www.missionsq.org/
Workers Compensation	Company Nurse	(877) 854-6877	

City of San Ramon Benefits Team

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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 and reviewed your EOB (except for copays).
Family Deductible	The maximum dollar amount any one family will pay out in individual deductibles in a year. IMPORTANT: If you enroll for family coverage on the PPO plan, one or more family members will need to meet the deductible.
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.
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.

Key Terms

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.

Important Plan Notices and Documents

The following pages are mandatory notices that all employers are required to provide to their employees. The contents of the messages may or may not apply to you. If you have any questions about these notices, please contact Human Resource

SUMMARY OF BENEFITS AND COVERAGE NOTICE

Choosing your health plan is an important decision. To assist you with this process, each health plan available to you through the California Public Employees' Retirement System has produced a Summary of Benefits and Coverage (SBC). In addition, the federal government has compiled a glossary of common health insurance terms. Together, these documents provide important information to help you better understand your health benefit coverage and more easily compare health plan options.

To view the SBCs and glossary online, visit www.calpers.ca.gov/page/active-members/health-benefits/plans-and-rates or any of the health plan websites below. To request a free paper copy of the SBC and glossary, please contact each health plan directly.

*****To enroll in this health plan, you must belong to the specific employee association and pay applicable dues. Please contact Human Resources with questions regarding eligibility and enrollment.

AVAILABILITY OF PRIVACY PRACTICES NOTICE

The Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we periodically remind you of your right to receive a copy of the HIPAA Privacy Notice. You can request a copy of the Privacy Notice by contacting Human Resources.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in the City's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in the City's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days (60 days for CalPERS medical plans) after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days (60 days for CalPERS medical plans) after the marriage, birth, adoption, or placement for adoption.
- 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 you request a change due to a special enrollment event within the 31 days (60 days for CalPERS medical plans) 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. In addition, you may enroll in the City's health 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 right, you may add the dependent to your current coverage or change to another health plan.

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 to 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 benefits provided under our plans. If you would like more information on WHCRA benefits, call your plan administrator.

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.

AVAILABILITY OF SUMMARY INFORMATION

As an employee, the health benefits provided by the City of San Ramon represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The City of San Ramon offers a variety of benefit plans to eligible employees. The federal health care reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by the City of San Ramon are available on ESS or by contacting Human Resources.

NOTICE OF CHOICE OF PROVIDERS

HMO plans generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. Until you make this designation, your carrier will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carrier directly.
For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the City's plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your insurance carrier directly.

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

MEDICARE PART D

Important Notice from the City of San Ramon 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 San Ramon 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 San Ramon has determined that the prescription drug coverage offered by CalPERS 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 San Ramon coverage will not 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 CalPERS 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 San Ramon 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 San Ramon 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 the person 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 San Ramon 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, 2024
Name of Entity/Sender:	City of San Ramon
Contact-Position/Office:	Megan O'Donoghue, Human Resources Manager
Address:	7000 Bollinger Canyon Road, San Ramon, CA 94583
Phone Number:	(925) 973-2633

CMS Form 10182-CC Updated April 1, 2011, According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 | Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid

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

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ |
Phone: 1-877-438-4479
All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

MAINE – Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 617-886-8102

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp | Phone: 1-800-657-3739

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

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

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

The information in this booklet is a general outline of the benefits offered under the City of San Ramon benefits program. Specific details and plan limitations are provided in the Evidence of Coverage (EOC), which is based on the official Plan Documents that may include policies, contracts, and plan procedures. The EOC and Plan Documents contain all the specific provisions of the plans. In the event that information in this booklet differs from the Plan Documents, the Plan Documents will prevail.

Notes

EMPLOYEE BENEFITS OVERVIEW DESIGNED AND DEVELOPED BY

IN CONJUNCTION WITH THE CITY OF SAN RAMON

HUMAN RESOURCES DIVISION
7000 BOLLINGER CANYON ROAD
SAN RAMON, CA 94583
(925) 973-2523