City of Campbell

2026 Elected Officials Summary of Benefits

Human Resources Division
(408) 866-2122
HR@campbellca.gov

Welcome to the City of Campbell!

Welcome to the 2026 Elected Officials Summary of Benefits, your single source document for the information you need to make informed decisions about your benefits for yourself and your eligible family members.

The 2026 Elected Officials Summary of Benefits is intended to be a summary of the benefits offered to you and your eligible family members, including:

- Medical insurance
- Dental insurance
- Vision insurance
- Life insurance

State law authorizes the City Council to determine health and welfare benefits for members of the City Council.

Additionally, City of Campbell **Resolution No. 11234** establishes that the level of health and life insurance benefits provided to Councilmembers be established at the same monthly benefit amount provided to employees in the City's classified management group. However, Councilmembers who waive the right to medical coverage would not be entitled to the opt. out cash rebate.

INTRODUCTION

Who is Eligible?

The Mayor, Vice Mayor, City Councilmembers and their eligible dependents may enroll in the city's medical, dental and vision programs.

Eligible family members that may enroll in our medical, dental and vision plans include:

- Your current spouse or domestic partner.
- Your natural children, stepchildren, domestic partner's children, foster and/or adopted children under 26 years of age.
- Your disabled children age 26 or older.
- A tax-qualified dependent.

Who is Not Eligible?

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

- Parents, grandparents, and siblings.
- Any individual who is covered as an Elected Official of the City of Campbell cannot also be covered as a dependent.

When Can I Enroll?

Coverage for newly Elected Officials begins on the first day of the month following the Elected Official's first day in office (date of hire). Newly Elected Officials who do not make an election or do not provide proof of medical care coverage outside of the City within **60 days** of becoming eligible will automatically be enrolled for Elected Official only coverage under Kaiser Traditional HMO.

Elected Officials may also enroll in or change a medical, dental, or vision care plan offered by the City during open enrollment, or following a qualifying life event. Open enrollment is generally held in September and the changes made during open enrollment become effective on January 1st of the following year.

Make sure to contact the Human Resources Division within the following days if you have a qualifying life event and need to make a change (add or drop) to any of your coverage:

- **Medical Coverage** - within 60 days
- **Dental Coverage** - within 30 days
- **Vision Coverage** - within 30 days

Adding or Removing Dependents?

Elected Officials are responsible for reaching out to the Human Resources Division to update dependent status in addition to providing supporting documentation during the plan year to advise of a qualifying event (i.e., marriage, birth, death, divorce, dissolution of domestic partnership, ineligibility of dependent child due to age/school status, etc.). Such notification must be made within **30 days** that the status change occurs. Failure to submit notification in timely manner may impact dependent eligibility for health care continuation and may result in you incurring liability for medical expenses for non-eligible dependents.

WHEN CAN YOU MAKE CHANGES TO YOUR BENEFITS

Other than during the annual open enrollment period, you may not change your coverage unless you experience a qualifying event. Qualifying life events include:

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

IMPORTANT! — THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any changes you make must be consistent with the change in status,
2. You must make the changes within **60 calendar days for medical coverage and within 30 calendar days for dental and vision** of the date the event occurs (marriage, birth, etc.).
3. With the exception of births, life events take effect the first of the following month after the life event effective date.

DEPENDENT ELIGIBILITY VERIFICATION

All Elected Officials adding dependents will be asked to provide documentation verifying eligibility of their covered dependents. The following chart is an easy guide to which form and documents must be submitted. Failure to submit appropriate documentation will result in dependent's ineligibility for coverage.

Dependent Type	Eligibility Definition	Documents Required for Verifying Eligibility
Spouse or Domestic Partnership	Person to whom you are legally married	• Marriage Certificate **OR** • Declaration of Partnership filed with the California Secretary of State **AND** • Social Security Card **AND** • Valid ID
Natural Child(ren) Under Age 26	Minor or adult child(ren) of Elected Official who is under age 26 years	• Birth Certificate **AND** • Social Security Card
Step Child(ren) Under Age 26	Minor or adult child(ren) of Elected Official's spouse who is under age 26 years	• Birth Certificate **AND** • Marriage Certificate showing Spouse as Parent **AND** • Social Security Card

Adopted Child	Minor or adult child(ren) legally adopted by Elected Official who is married or unmarried under age 26 years	• Adoption Court Order Document **AND**
		  ○ Certificate must name Elected Officials as one of the parents/guardians.
		  ○ Court documents must be recorded and cannot be in draft form.
		• Social Security Card

Children of Domestic Partners Under Age 26	Minor or adult child(ren) of Elected Official's domestic partner who is under age 26 years	• Documentation of your current relationship to your domestic partner **AND** • Birth Certificate **AND** • Social Security Card
Disabled Children (No age limit)	Natural child, step child or adopted child of Elected Official who is over age 26 years and incapable of self-care due to physical or mental illness.	• Birth Certificate **AND** • Certification of Disability from Social Security **OR** • Document of Disability from Physician if not SSA Certified **AND** • Social Security Card
Other Qualifying Relatives Under Age 26	• Meets requirements of IRS Code. Sec. 105(b) • Under age 26 years	• Birth Certificate Showing Individual to be an Eligible Relative **AND** • Affidavit of Parent-Child Relationship **AND** • Social Security Card

PLEASE NOTE: The deduction for a domestic partner is not a pre-tax qualified deduction. Since this is not a pre-tax qualified deduction, City Elected Officials will be assessed imputed taxable income on their W2 tax statement at the end of the year that needs to be reported when filing taxes. It is recommended that the Elected Officials consults with a qualified tax specialist or accountant for any additional questions.

CalPERS RETIREMENT PLAN

Plan Details: California Public Elected Officials Retirement System — CalPERS
Employer Plan Code: 2284 24 7568
(888) 225-7377
www.calpers.ca.gov

	PERS Options	Elected Officials contribution	City Contribution
Classic Miscellaneous Members (hired prior to March 7, 2011)	• 2.5 % at age 55 • Highest 36 month salary • Military service buy back option • 1959 Survivor Benefit – Level 3, One-half continuance • Credit for Unused Sick Leave • Credit for Peace Corps, AmeriCorps VISTA, AmeriCorps Service	8%	10.72% + Employer payment of unfunded liability
Classic Miscellaneous Members (hired after March 6, 2011)	• 2 % at age 60 • Highest 36 month salary • Military service buy back option • 1959 Survivor Benefit – Level 3, One-half continuance • Credit for Unused Sick Leave • Credit for Peace Corps, AmeriCorps VISTA, AmeriCorps Service	7%	10.72% + Employer payment of unfunded liability
New Miscellaneous Members (hired after December 31, 2012*)	• 2 % at age 62 • Highest 36 month salary • Military service buy back option • 1959 Survivor Benefit — Level 3, One-half continuance • Credit for Unused Sick Leave • Credit for Peace Corps, AmeriCorps VISTA, AmeriCorps Service	8.5%	10.72% + Employer payment of unfunded liability

*Classic Miscellaneous Members hired after December 31, 2012 will be enrolled in the **Classic Miscellaneous Members (hired after March 6, 2011)** plan, listed above.

CalPERS MEDICAL COVERAGE

The City's medical coverage is designed to help maintain wellness and protect you and your family from major financial hardships in the event of illness or injury. The City contracts with CalPERS for medical insurance coverage and contributes towards the premiums for several plan options available to Elected Officials and their eligible dependents. For detailed information about the plans please visit the following website: https://www.calpers.ca.gov/page/active-members/health-benefits/plans-and-rates.

2026 City Contribution towards the premium:

Employee	Employee +1	Employee + Family
$1,151.05	$2,302.10	$2,992.72

If the cost of the selected medical insurance plan and any other optional group insurance plans exceed the City's Cafeteria Plan Allotment, the balance will be paid by payroll deductions from the salary of the respective Elected Official.

Elected Officials declining medical coverage through City sponsored plans must file proof of alternative medical insurance coverage with the Human Resources Division. Elected Officials declining coverage must provide waiver verification documentation annually (during open enrollment) or within 30 days after the start of the plan year.

HMO Plans:

Medical Plans	Elected Official	Elected Official +1	Elected Official + Family
Anthem Blue Cross Select HMO	**$1,336.29**	**$2,672.58**	$3,474.35
Anthem Blue Cross Traditional HMO	**$1,612.08**	$3,224.16	$4,191.41
Blue Shield Access+ HMO	**$1,301.95**	$2,603.90	$3,385.07
Blue Shield Trio*	$1,166.58	**$2,333.16**	$3,033.11
Kaiser Permanente HMO	$1,168.86	$2,337.72	$3,039.04
UnitedHealthcare SignatureValue Alliance	$1,290.06	$2,580.12	$3,354.16
UnitedHealthcare SignatureValue Harmony	$1,133.09	$2,266.18	$2,946.03
Western Health Advantage HMO	$969.58	$1,939.16	$2,520.91

PPO Plans:

Medical Plans	Elected Official	Elected Official +1	Elected Official + Family
PERS Platinum	$1,120.58	$2,241.16	$2,913.51
PERS Gold	$1,670.14	$3,340.28	$4,342.36

*Limited Region

VISION COVERAGE - Elected Officials

The City's vision program provides the below coverage **plus** progressive lenses every 12 months.

This benefit is fully paid for by the City. The City pays the entire premium of $33.11 per month for Elected Officials and their eligible dependents.

Note: If you've received eye care services from an out-of-network provider, you may need to submit a claim to request reimbursement. For more information, please visit: https://www.vsp.com/claims/submit-oon-claim.

Your VSP Vision Benefits Summary

CITY OF CAMPBELL and VSP provide you with an affordable vision plan.

PROVIDER NETWORK:
VSP Signature
EFFECTIVE DATE:
08/01/2022

vsp vision care

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
Your Coverage with a VSP Provider			
WELLVISION EXAM	• Focuses on your eyes and overall wellness	$10 for exam and glasses	Every 12 months
ESSENTIAL MEDICAL EYE CARE	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES			
FRAME*	• $140 featured frame brands allowance • $120 frame allowance • 20% savings on the amount over your allowance	Combined with exam	Every 24 months
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Combined with exam	Every 12 months
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 40% on other lens enhancements	$0 $80 - $90 $120 - $160	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	• $120 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
EXTRA SAVINGS	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.		
	Routine Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		
YOUR COVERAGE GOES FURTHER IN-NETWORK			
With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network provider.			

Group Plan:
Vision Service Plan - VSP
Plan Numbers:
12 098798 0003 (MGMT)
(800) 852-7600
www.vsp.com

DENTAL COVERAGE - DELTA DENTAL PPO - Elected Officials

This benefit is fully paid for by the City. The City pays the entire premium of $179.04 per month for Elected Officials and their eligible dependents.

Plan Benefit Highlights for: City of Campbell
Group No: 01744 - 00002

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the month dependent turns age 26			
Deductibles	$25 per person per lifetime			
Maximums D & P counts toward maximum?	$2,500 per person each calendar year Yes			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100%	80%
Basic Services Fillings, posterior composites and sealants	80%	80%
Endodontics (root canals) Covered Under Basic Services	80%	80%
Periodontics (gum treatment) Covered Under Basic Services	80%	80%
Oral Surgery Covered Under Basic Services	80%	80%
Major Services Crowns, inlays, onlays and cast restorations	50%	50%
Prosthodontics Bridges, dentures and implants	50%	50%
Orthodontic Benefits Adults and dependent children	50%	50%
Orthodontic Maximums	$2,500 Lifetime	$2,500 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Group Plan:
Delta Dental Plan of California
Group Number: 174-0002 (MGMT)
(888) 335-8227
www.deltadentalca.org

LIFE INSURANCE

Administered by The Standard

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 and pay for large expenses such as housing and education, as well as day-to-day living expenses. Group Basic Life Insurance from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an eligible member's or his or her dependent's covered death.

The City pays the entire premium of $23.25 per month.

Coverage

Elected Officials: The City provides basic life insurance coverage in the amount of $50,000 and Accidental Death and Dismemberment (AD&D) coverage in the amount of $50,000.

The City also offers voluntary basic dependent life insurance coverage for an eligible spouse and/or children (up to age 21) that can be purchased for $0.49/month per $1,000 of coverage. Elected Officials must purchase additional supplemental life insurance for themselves in order to purchase dependent life insurance coverage.

VOLUNTARY INSURANCE PLANS

If your medical insurance premium costs less than the City's contribution, you may choose to apply your remaining funds to additional insurance(s).

As an Elected Official, the City of Campbell allows you to apply for additional life coverage for you and your family. Additional Insurances available for purchase:

- Accident Insurance
- Cancer Insurance
- Identity Protection

If you are interested in please contact Lisa Garon via email at lisa.garon@workterra.com.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Administered by Claremont EAP, Powered by uprisehealth

The Claremont Employee Assistance Program (EAP) helps you resolve personal issues before they become more serious and difficult to manage. You and your eligible family members can receive professional, confidential counseling at no cost. We also provide access to resources that can help you address virtually any personal concern or question.

Overview of the Employee Assistance Program

The City's EAP Program is an essential component of the City's work-life benefit, offering work-life assistance to our employees and family members. Personalized consultations, resources and referrals are available at no cost for a wide range of needs that include:

Counseling Visits - The EAP offers 8 free counseling visits per incident, per rolling 12 months for almost any personal issue. Claremont EAP will work with you to find the most appropriate counselor to meet your needs.

- Marital/Relationship issues
- Parenting/Family issues
- Work concerns
- Depression
- Anxiety
- Stress
- Substance abuse
- Other issues impacting your quality of life

Work/Life Referrals - consultants can provide you with referrals and information for services such as: child care, elder care, pet care, adoption assistance, school/college assistance, health and wellness, and convenience referrals.

Legal Consultation - EAP offers up to 30 minutes of free consultation with an attorney per issue to answer your legal questions, either in-person or over the phone. On-going services, if required, are offered at a 25% discount. EAP can assist with legal issues such as: divorce, child custody, real estate, personal injury, criminal law, and free simple will kits.

Financial Consultation - Financial professionals and licensed CPAs will provide up to 30 minutes of telephonic coaching per issue on a range of financial issues such as: budgeting, debt management, tax planning, retirement planning, home buying strategies, college planning, and credit repot coaching.

Claremont Personal Advantage - Claremont Personal Advantage (CPA) has over 20,000 online resources at your fingertips 24/7. Resources and tools include: information on health, finance, legal issues, personal growth, stress, emotional wellbeing, family life, and more; in the form of assessments, quizzes, videos, articles, FAQs, forms, calculators, and more!

Call toll-free, 24 hours a day, seven days a week
800-834-3773

OTHER PAYS

Auto Allowance

The City provides an auto allowance for the following job classifications:

Mayor	$160/month
Vice Mayor	$160/month
Councilmembers	$160/month

WHEN YOUR BENEFITS TERMINATE

Your **medical plan** coverage will end on the last day of the month following your date of termination or loss of eligibility. For example, if your termination date is November 11, your medical coverage will end on December 31.

Your **dental and vision plan** coverage ends on the last day of the month of your date of termination or loss of eligibility. For example, if your termination date is November 11, your medical coverage will end on November 30.

Your life insurance coverage, through The Standard, ends on the date of your termination.

PLAN DETAILS AND QUICK LINKS

Plan Name	Plan Details	Contact Information & Links
California Public Employees Retirement System (CalPERS)	Employer Plan Code: 2284 24 7568	• (888) 225-7377 • www.calpers.ca.gov • myCalPERS Account: https://my.calpers.ca.gov/web/ept/public/systemaccess/selectLoginType.html
Delta Dental	Group Number: • 174-0002	• (888) 335-8227 • www.deltadentalca.org • Member Log In: https://www1.deltadentalins.com/login.html
The Standard • Life insurance	Policy Number: • 309784	• (800) 368-1135 • www.standard.com
VSP • Vision insurance	Plan Number: • 12 098798 0003	• (800) 852-7600 • www.vsp.com • Member Portal: Log in • FAQs: https://www.vsp.com/faqs
WorkTerra • Additional insurances		• (800) 229-7683 • www.workterra.com

PLAN CONTACT NUMBERS

Plan Name	Administrator	Plan Information
Claremont Behavioral Services • Employee Assistance Program (EAP)	Account Number: • 0376	• (800) 834-3773 • www.claremonteap.com
Anthem Blue Cross (Basic) (HMO) • Select HMO • Traditional HMO	Anthem Blue Cross (855) 839-4524	CVS Caremark is the Pharmacy Benefit Manager (PBM) providing prescription benefits for this medical plan.
Blue Shield of California (HMO) • Blue Shield Access+ HMO • Blue Shield Trio HMO	Blue Shield of California (800) 334-5847	Blue Shield of California administers their own prescription drug benefits.
Kaiser (HMO)	Kaiser Permanente (800) 305-1220	Kaiser administers its own prescription benefits.
UnitedHealthcare (Basic) (HMO) • UnitedHealthcare SignatureValue Alliance • UnitedHealthcare SignatureValue Harmony	UnitedHealthcare (877) 359-3714	CVS Caremark is the Pharmacy Benefit Manager (PBM) providing prescription benefits for this medical plan.
Western Health Advantage (HMO)	Western Health Advantage (888) 942-7377	CVS Caremark is the Pharmacy Benefit Manager (PBM) providing prescription benefits for this medical plan.
PERS Plans (PPO) • PERS Platinum Basic • PERS Gold Basic	Anthem Blue Cross (877) 737-7776	The Platinum plan has no geographical restrictions. It provides coverage anywhere in the world. The Gold plan is only available in California.

WORDS YOU NEED TO KNOW

Health/medical insurance seems to have its own language. You will get more out of your plans if you understand the most common terms, explained below.

MEDICAL

OUT-OF-POCKET COST - A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

DEDUCTIBLE - The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

CO-INSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Co-insurance is always a percentage totaling 100%. For example, if the plan pays 70% co-insurance, you are responsible for paying your co-insurance share, of 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service. For example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - In-Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

GENERIC DRUG - A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

SPECIALTY DRUG – Medication that requires close supervision and monitoring for serious and/or complex chronic conditions. These medications are often associated with very high costs and require special storage, handling, or dosing procedures.

DENTAL

BASIC SERVICES - Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTIC AND PREVENTIVE SERVICES - Generally include routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES - Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

IMPORTANT PLAN NOTICES AND DOCUMENTS

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Call your health plan's Member Services for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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 carrier directly at the number at the back of your medical card.

AVAILABILITY OF PRIVACY PRACTICES NOTICE

We maintain the HIPAA Notice of Privacy Practices for the City of Campbell describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the HR, Benefits Division.

NOTICE OF CHOICE OF PROVIDERS

Health Maintenance Organization (HMO) plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, your carrier designates 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 carrier directly. For children, you may designate a pediatrician as the primary care provider.

MICHELLE'S LAW

The City of Campbell plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from college (postsecondary educational institution). 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 their coverage to be extended, contact the Human Resources Division 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 their benefits.

IMPORTANT PLAN NOTICES AND DOCUMENTS (continued)

NON DISCRIMINATORY TESTING FOR CAFETERIA PLANS GOVERNED UNDER CODE SECTION 125

IRS requires each plan governed under “Code Section 125 cafeteria plans” to go through nondiscriminatory testing each plan year to see if our plan passes. These plans offer a favorable pre-tax benefit and the IRS requires plans to conduct special non-discriminatory testing on all plans that offer a favorable pre-tax benefit each year.

The codes nondiscrimination rules exist to prevent plans from being designed in such a way that it discriminates in favor of individuals who are either highly compensated Elected Officials or are otherwise key Elected Officials in the organization.

The plans will not pass the tests if the highly compensated Elected Officials or key Elected Officials elect more benefits under the plan than Elected Officials who are not highly compensated. This is called a “Concentration Test”. If plans fail the concentrations testing, adjustments may be required to the yearly election amounts. Adjustments will not be made if the plan passes.