CITY OF MISSION VIEJO

MISSION VIEJO

Make Living Your Mission

Summary Of Benefit Plans - 2018

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Introduction

The City of Mission Viejo (City) takes pride in offering a benefits program, which provides flexibility for the diverse and changing needs of its employees.

This benefits summary briefly describes the highlights of the City's benefit plans. The official plan documents, when finally executed and as amended from time to time, govern the plans and should be consulted for additional detail on coverages and exclusions. If there is a conflict between this summary and the official plan documents, the official plan documents will prevail. At any time and for any reason, the City may exercise its legal right to modify, replace, or terminate any of the benefit plans it provides.

Fixed Monthly Employer Contribution

Employees are eligible to receive a Fixed Monthly Flex Contribution based upon their hire date, enrollment level in a medical plan (i.e. employee only, plus one, or family), and their full-time equivalency (FTE). Please see the back page titled Premium Schedule for a complete list of the current Fixed Monthly Employer Contributions by tier. You can also reference the Employer Contribution Schedule Personnel Policy.

Who Is and Is Not Eligible

Individuals are eligible to participate in employee benefits if they fall into any of the following categories:

- A full-time employee
- An at-will executive employee
- A part-time employee in a budgeted position listed on the Authorized Position Schedule and is scheduled to regularly work twenty (20) or more hours per week
- A member of the City Council
- An Hourly/Seasonal/Temporary employee determined to have worked thirty (30) or more hours per week during an initial or standard measurement period.

An eligible employee may also enroll their eligible dependents for benefit coverage. Eligible dependents include:

- Spouse (copy of marriage license and the person's social security number is required)
- Domestic Partner (You are required to complete an Affidavit for Domestic Partnership with the State of California, and your contribution for their coverage is made on an after-tax basis.)
- Eligible children are defined as natural, adopted, step, or domestic partner's children up to age 26 (a copy of the birth certificate and the child's social security number is required)
- An Economically Dependent Child is eligible for medical insurance enrollment only. Another person's child may be eligible for coverage as an Economically Dependent child if the employee has been granted legal custody or joint legal custody of the child; or the child resides with the employee **and** is economically dependent upon the employee (You are required to complete the Affidavit of Eligibility form which is a legally binding document and to report any changes pertaining to the child's dependency).

Who Is Not Eligible: The following is a list of individuals that are not allowed to participate in the City's group benefit plans:

- Former spouses
- Dependent Children over age 26
- Dependent Children's spouses
- Parents or Parent-in-laws
- Grandparents
- Stepchildren of former spouses*
- An hourly/seasonal/temporary employee working less than thirty (30) hours per week
- Any individual in any other classification not directly approved by City Council

*Stepchildren of former spouses are eligible when the employee retains custody. They must certify as "economically dependent". The dissolution of marriage dissolves the relationship as "step". Similarly, a domestic partner's child must be certified as "economically dependent" if the partnership dissolves, but the employee retains custody of the child.

The City of Mission Viejo and its benefit carriers may audit an employee's documentation to determine whether an enrolled dependent is eligible according to the plan requirements. This audit may occur either randomly or in response to uncertainty concerning dependent eligibility.

Dual Coverage

Employees cannot be enrolled in a CalPERS health plan in their own right ("self") and as a dependent of another member enrolled in a CalPERS health plan. Upon discovery, dual enrollments are cancelled on a retroactive basis, and the health plans will bill the employee for services provided on behalf of ineligible family members. However, employees can be enrolled as a dependent in another family member's health plan as long as it is: 1) a non-CalPERS administered plan; and 2) that plan allows dual coverage in their contract.

New Employees Effective Date of Coverage

As a benefit eligible employee, you have 60 calendar days from the date of your initial eligibility to enroll, or decline to enroll, yourself or yourself and all eligible family members in a benefit plan. The effective date is the first day of the month following the date Human Resources receives your enrollment elections via Munis Employee Self-Service (ESS). If you do not submit your benefit elections within 60 calendar days of your initial eligibility, you will be automatically enrolled in the "Employee Only" category of the lowest cost health plan, excluding the Health Net Salud y Mas plan, the cost of which will be offset by your applicable Fixed Monthly Flex Contribution. You will not be able to make any changes to your benefits until the next Open Enrollment period unless you experience a "qualified status change".

Annual Open Enrollment

Each year during open enrollment, you have the opportunity to make changes to your benefit choices. The open enrollment period occurs in the fall, with your new elections taking effect on January 1st of the following year. These elections remain effective through December 31st of that following year and can only be changed in the case of a qualified status change. During open enrollment you may:

- Choose a different option where choices are available
- Add or drop dependents from your coverage
- Elect to participate in the Flexible Spending Accounts for the upcoming year

Employees who do not submit the required benefit election forms during Open Enrollment will be enrolled in the same elections as the prior year, with the exception of Medical and/or Dependent Care Reimbursement Accounts. Any eligible remaining balance from the Fixed Monthly City Contribution will be placed in the taxable Cash Option.

Waiving of Medical Insurance

Employees may conditionally waive medical insurance for themselves if they can provide adequate documentation to prove they have minimum essential group medical coverage elsewhere. In addition, the employee must annually submit a completed "Waiver of Benefits and Release Agreement Form" attesting they have alternative minimum essential coverage from another group plan provider. If an employee does not provide adequate documentation, as determined by the City, then the employee may not waive medical insurance. If you waive the City's group medical plan, you are required to notify the City if you experience a mid-year status change which results in loss of minimum essential group medical coverage. Notice must be made to the Human Resources Division within 30-calendar days of such status change. Please see the Human Resources Division for further conditions that may apply.

Section 125 Plan

The City administers the benefit plans as allowed under Section 125 of the Internal Revenue Code (IRC) that lets employees pay for eligible benefit premiums on a pre-tax basis. The advantage to you is that the premiums are taken out of your paycheck before taxes are deducted. This lowers your taxable income, increasing your take home pay. The amount you save will depend on how much premium is paid with before-tax dollars, your tax bracket, and your earnings when you enroll.

The written plan document and the summary plan description specifically describe all benefits and establish rules for eligibility and elections.

Qualified Status Changes

Once you make your benefit choices, you cannot make changes until the next open enrollment period unless you experience a qualified status change. If such an event occurs, you must email the Human Resources Division within 30-days of the event in order to make changes to your current plans. Examples of qualified status changes include:

- Marriage or Domestic Partner Registration
- Birth, Adoption or placement for adoption
- Divorce or annulment of an employee's marriage or Dissolution of Domestic Partnership
- Death of a spouse, domestic partner or dependent
- Change in employee's, spouse's, domestic partner's or dependent's employment status that affects eligibility under their plan
- Dependent no longer meets eligibility criteria or becomes ineligible for other coverage
- Court order results in the employee gaining or losing custody of a dependent
- Coordination of spouse's or domestic partner's annual election period

Divorce or Termination of Domestic Partnership

If you divorce or terminate a domestic partnership, your former spouse/domestic partner is no longer eligible to be enrolled in the City's benefit plans, even if the court orders you to provide health coverage for them. The coverage terminates on the first day of the month in which the final decree of divorce or termination is granted. You must submit a copy of your final divorce decree or Notice of Termination of Domestic Partnership form to Human Resources (if active) or CalPERS (if retired).

Employees email the Human Resources Division of the change and attach a copy of the divorce decree. You may also want to review and/or update your beneficiary designations and residence address on file with CalPERS for your retirement account, with Voya for your life insurance, and either ICMA or Nationwide for your deferred compensation account(s).

Carrier Information At-A-Glance

Carrier	Policy/Group Number	Phone Number
AFLAC		949-954-1300
Anthem HMO		855-839-4524
Blue Shield	PH0001	800-334-5847
Delta Preferred	10535-0001	888-335-8227
Delta Care	72432-0001	800-422-4234
Health Net of California		888-926-4921
Discovery Benefits		866-451-3399
ICMA-RC	303058 (457 plan); 106509 (401 plan), 803691 (RHS plan)	800-669-7400
Voya Financial	31640-7	800-328-4090
Kaiser	5705	858-614-3545
MHN EAP		800-242-6220
Nationwide Retirement Solutions	041522-001 (457 plan); 0441583001 (401 plan)	800-769-4457
PERS Retirement	1476	888-225-7377
PERS Care	KB050B	877-737-7776
PERS Choice	CB050A	877-737-7776
PERS Select	CB50A	877-737-7776
Sharp Health Plan		855-955-5004
United Healthcare		877-359-3714
Vision Service Plan	12121476	800-877-7195

Medical Plans

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 of Mission Viejo's medical plans are administered through the California Public Employee's Retirement System (CalPERS) and are subject to the rules of the Public Employees' Medical and Hospital Care Act (PEMHCA).

Selecting a health plan for yourself and your family is one of the most important decisions you will make. This decision involves balancing the cost of each plan, along with other features, such as access to doctors and hospitals, pharmacy services, and special programs for managing specific medical conditions. Choosing the right plan ensures that you receive the health benefits and services that matter to you. You are encouraged to visit the CalPERS website to access online resources and publications to learn about your medical plan choices.

The 2018 Health Benefit Summary publication provides valuable information to help you make an informed choice about your health care providers. It compares covered services, co-payments, and benefits for each CalPERS health plan. It provides information about plan availability by county and a chart summarizing the key differences between a Health Maintenance Organization (HMO) and a Preferred Provider Organization (PPO).

In addition, the 2018 Health Program Guide describes CalPERS Basic health plan eligibility, enrollment, and choices. It provides an overview of CalPERS health plan types and tells you how and when you can make changes to your plan (including what forms and documentation you will need).

Since these publications only provide a general overview of benefits. Please refer to each health plan's Evidence of Coverage (EOC) booklet for the exact terms and conditions of coverage. Health plans mail EOC's to new members at the beginning of the year, and to existing members upon request. You can also access the EOC's online by visiting the CalPERS website.

SERVICE AREAS: Please ensure you have correctly evaluated the service area of each health plan. Not all plans service all areas of Orange and San Diego Counties.

SPECIFIC PROVIDER NEEDS: If a specific doctor, medical group, or hospital is preferred, a plan must be selected which allows access to the specific provider. Each enrollee needs to contact the carrier(s) and/or provider directly to inquire about the availability of the specific provider BEFORE enrolling.

When employees enroll into a health plan, services are provided through the health plan's delivery system and the continued participation of any one doctor, hospital, or provider network **is not guaranteed**. The provider network may change during the plan year and often does. Employees may be permitted to select another provider, but not another plan.

DUAL COVERAGE: The CalPERS Health Benefits Program **does not permit dual coverage**. Employees who are already covered as a dependent of another PEMHCA enrollee may not be enrolled as "self" with the City of Mission Viejo. Therefore, an employee must cancel their prior dependent enrollment in the other PEMHCA plan in order to enroll in the City of Mission Viejo plan. Upon discovery, dual enrollments are cancelled on a retroactive basis, and the carriers will bill the employee for services provided on their behalf of ineligible family members.

Dental Plans

Next to medical insurance, dental coverage is the single most requested benefit among employees and an important part of your overall health and well-being. You may choose from two different plans offered by Delta Dental. When choosing between a prepaid/DHMO plan an indemnity/PPO plan, you should consider you and your dependents dental history, level of dental care required, costs/budget, and provider in the network.

DeltaCare Program

DeltaCare is a DHMO plan and provides you and your family with quality dental benefits at an affordable cost. The DeltaCare program is designed to encourage you and your family to visit the dentist regularly to maintain your dental health. When you enroll, you select a contract dentist to provide services. The DeltaCare network consists of private practice dental facilities that have been carefully screened for quality. Your selected contract dentist will take care of your dental care needs. If you require treatment from a

specialist, your contract dentist will handle the referral for you. Under the DeltaCare program, many services are covered at no cost, while others have co-payments for certain benefits. See the summary plan document or provider directory for further details and list of required co-payments. The City' participates in plan CA10B.

Delta DPO Program

The Delta Dental DPO plan is Delta's preferred provider program. It allows you the freedom to visit any licensed dentist from the Delta Dental Premier indemnity network. However, there are advantages to visiting a Delta Dental DPO network dentist instead of a Premier or non-Delta Dental dentist. Please refer to the Benefit Highlights Sheet for further details.

Vision Plan

Keep your life and future in focus with eye care services through Vision Service Plan (VSP). When you obtain services from a VSP doctor, you get the most value from your VSP benefit. Please refer to the VSP Benefit Highlights Sheet for further plan details. VSP offers two convenient ways to locate a VSP doctor near your home or work, or to verify your doctor is a VSP doctor. Simply visit VSP at www.vsp.com or call Member Services at (800) 877-7195. Please note that VSP does not issue ID cards.

Flexible Spending Accounts (FSA)

You can make your paycheck go further by taking advantage of the tax savings associated with participating in a Flexible Spending Account (FSA). You can set up one FSA for health care expenses and another to pay for the cost of caring for your dependents while you are at work. Both types of accounts are administered through Discovery. A Discovery enrollment form is required to enroll in either one or both of these plans. An enrollment form is **required** each year during Open Enrollment for the next calendar plan year.

Health Care Spending Account

The Health Care Spending Account is a tax-free way to pay any qualified out-of-pocket expenses associated with medical, dental, and vision care for yourself and any family members who are legal dependents. You may contribute between $180 and $2,500, pre-tax, annually to this account. Examples of eligible expenses include:

- Annual deductibles
- Co-payments
- Coinsurance amounts

Dependent Care Spending Account

The Dependent Care Spending Account allows you to pay for child or elder care expenses on a tax-free basis. You may contribute between $300 and $5,000 annually towards this account. Examples of eligible expenses include:

- Care of a child under age 13 or dependents of any age not capable of caring for themselves because of a mental or physical handicap, when the purpose of that care is to allow you and/or your spouse to work. (See your tax advisor for further details).
- Day care centers, preschool and nursery schools
- Before and after school care

Important IRS Rules

Plan carefully. Once you enroll, your FSA contributions must remain in effect for the entire plan year unless you experience a qualified status change. Your contributions can only be used to pay eligible expenses you incur during the plan year. Effective January 1, 2015, you can roll over up to $500 of unused Healthcare FSA funds to the following calendar year. After March 31st, the deadline for filing all claims for the previous plan year, any additional money left in your account(s) must be forfeited.

Military Reservists Exception: In accordance with the Heroes Earnings Assistance and Relief Tax Act of 2008, qualified military reservists who participate in a flexible spending account program may withdraw FSA funds (and avoid the use-it-or-lose-it rules) when they are called to active duty for 180 days or more or for an indefinite period. The withdrawal must be made during a period beginning on the day the reservist is called to active duty and ending on the last day of the coverage period of the FSA plan that occurs during the period of active duty.

Life Insurance

Life Insurance offers peace of mind and important financial protection for your family in the event of your death. The City pays 100% of the monthly premiums associated with your Basic Life, and Accidental Death & Dismemberment (AD&D) coverage. Your Basic Life benefit is equal to two times your basic annual earnings (BAE) to a maximum benefit of $300,000. This coverage is offered to you on a guaranteed issue basis, which means you do not need to provide any medical information to be enrolled into the plan. All you have to do is complete the enrollment form. Your policy also contains an "Accelerated Death Benefit" option. The Accelerated Death Benefit proceeds are paid in one lump sum and are paid only once. This lump sum payout is the only Settlement Option available to you prior to your death. Life insurance amounts decrease starting on and after your 65th birthday. Refer to your Life Insurance Certificate and Disability Certificate for more detailed information and requirements.

Supplemental Life Insurance

In addition to any basic life insurance City of Mission Viejo provides, eligible employees may elect more coverage by enrolling in a Supplemental Term Life Insurance program. This Supplemental Life insurance is portable. If you change jobs or retire before the age specified in your certificate, you can keep your coverage until age 70. Basic and Supplemental Life Insurance is underwritten by ReliaStar Life Insurance Company.

For more information, such as rates, please review the Supplemental Term Life (STL) and AD&D Coverage and Rate Information sheet.

For Yourself

Within 30 days of hire, you may apply for supplemental term life (STL) coverage from in increments of $10,000, not to exceed five (5) times your BAE or $350,000, whichever is lesser. If you elect coverage that exceeds the guaranteed issue amount of $75,000, you will need to provide evidence of insurability that is satisfactory to Voya Financial before the excess can become effective. After 30 days of your hire date, you will are subject to medical underwriting.

For Your Spouse

If you elect the STL plan for yourself, you may elect STL coverage for your spouse. Your election may be made in increments of $5,000 to a maximum of $50,000 but you may not exceed 50% of your approved election. If you elect an amount that exceeds the guaranteed issue amount of $25,000, your spouse will need to provide evidence of insurability that is satisfactory to Voya Financial before the excess can become effective. Spouse STL rates and premiums are based on the employee's age, not the spouse's age. Spouse coverage terminates at age 70. Domestic partners are eligible for this coverage.

For Your Children

If you elect the STL plan for yourself, you may elect Life coverage for your dependent child(ren) between the ages of 6 months and 19 years (23 years if a full-time student) in the amount of $10,000. This benefit is limited to 10% of elected amount for child(ren) age birth to 6 months.

Short- and Long-Term Disability Plans

The City-paid disability benefits connect you to a source of income should you become sick or injured off the job and unable to work. The City pays the full cost of this important coverage through Voya Financial.

Short-Term Disability

You may be eligible for short-term disability (STD) benefits beginning on the fifteenth (15th) day of your sickness or disability. (There is a 14-day waiting period once your disability begins.) STD benefits replace

66 2/3% of your weekly earnings to a maximum benefit of $1,500 per week up to 90 consecutive days. Proof of disability is required. If you continue to be disabled after 90 consecutive days, you may be eligible for long-term disability benefits. Refer to your Disability Plan Certificate for more detailed information.

Long-Term Disability

Long-term disability (LTD) benefits replace 66 2/3% of your base monthly salary after your short-term disability coverage ends and your disability continues for more than 90 consecutive days. The maximum plan benefit is $8,000 per month up to 48 months or normal retirement age. Proof of disability is required. Refer to your Disability Plan Certificate for more detailed information.

Employee Assistance Program (EAP)

Life is unpredictable and things happen. To help you through the times when personal problems get in the way, the City provides the MHN Employee Assistance Program (EAP). This free and confidential service is offered to all employees and their dependents. The EAP offers trained counselors to help you through periods of difficulty, which may involve relationship and family problems, stress, conflicts at work, substance abuse, and other problems. You are encouraged to get help when you need it by calling the EAP at 1-800-242-6220.

Your EAP provides:

- Easy Access to Services – MHN's trained intake specialists and professional counselors are available 24-hours a day, 7-days per week, via a toll-free telephone number.
- Face-to-Face Evaluations – MHN has developed a comprehensive, nationwide network of licensed and experienced counselors, including psychologists, clinical social workers, certified alcohol and drug counselors, and marriage, family and work related concerns.
- Online – MHN's website has the information, self-help tools and resources that can help guide you through life's challenges as well as life's opportunities. Visit www.members.mhn.com for online assistance with your personal, family, and work related problems. The access code is missionviejo.
- Confidentiality – All calls and counseling are confidential, except as required by law (e.g. when a person's emotional condition is a threat to him or herself or others, or there is suspected abuse of a minor child, and in some states, spousal or elder abuse).

AFLAC Voluntary Plans & Pet Insurance

Major medical pays for doctors and hospitals. Aflac is insurance for daily living. When you're sick or hurt, Aflac pays cash benefits that you direct to help you and your family with unexpected expenses. The benefits are paid regardless of any other insurance you have. They have a range of plans that fit most budgets. Aflac can provide you and your family with coverage and security to help maintain your everyday life in case of illness or injury.

Filing a claim with Aflac is never 'wait and see.' Claims are usually processed within 4 days. The forms are also easy to complete. So while you're focusing on your health, they focus on getting you a check quickly.

Aflac pays you benefits even when you're healthy**.**

Aflac wants you to be healthy - that's why they promote preventative care. Get a routine physical, a mammogram, or an eye exam and they pay you*. It's that simple.

The Six (6) Available Aflac Plans to choose from are:

Accident / Injury Plan

After an accident, you may have expenses you've never thought about before. Can your finances handle them? It's reassuring to know that an accident insurance policy can be there for you through the many stages of care, from the initial emergency treatment or hospitalization, to follow up treatments or physical therapy.

In addition, your regular bills, such as the mortgage or rent, car payments and utility bills don't stop when

you're laid up after an accident. Aflac accidental injury benefits are paid directly to you, so you can use them to help with your normal bills.

Individual accident insurance is a way to stay ahead of the medical and out-of-pocket expenses that add up so quickly after an accidental injury - not just for emergency treatment, hospital stays and medical exams, but for other expenses you may face, such as transportation and lodging needs.

When you have a covered accident, they'll send cash benefits directly to you (unless you tell us otherwise) and you decide the best way to spend them. It's as simple as that.

Cancer Care Plan

While you can't always predict the future, Aflac believes it's good to be prepared. Aflac's cancer/specified-disease insurance is here to help you and your family better cope financially—and emotionally—if a positive diagnosis of cancer ever occurs. That way you can worry less about what may be lying ahead.

No one wants to experience a cancer diagnosis, but the fact is that the risk of getting cancer is great. In the United States, men have slightly less than a one in two lifetime risk of developing cancer; for women, the risk is a little more than one in three (*Cancer Facts and Figures 2012*, American Cancer Society). Aflac cancer/specified-disease insurance policy is designed to provide you with cash benefits during covered cancer treatments.

Hospital Indemnity Advantage Plan

Concerned about the cost of hospitalization? Rightly so—a hospital stay, even a short one, can be very expensive. Even with the best major medical insurance, your entire hospital bill probably won't be covered. And what about things health insurance was never intended to cover, like transportation and meals for family members, help with child care or time away from work? Often it's those unexpected expenses that add up quickly and force you to dip into your savings or borrow. A hospital confinement indemnity insurance policy is designed to provide you with cash benefits during a covered hospitalization.
No matter how good your major medical insurance is, when you're hospitalized for an injury or illness there will probably be medical expenses and out of pocket costs that aren't covered. A hospital confinement indemnity insurance policy provides cash benefits to use as you see fit. The hospitalization benefits are predetermined and paid regardless of any other insurance you have, and you have a choice of applying for basic to more robust supplemental hospitalization insurance. Whether you want a hospital indemnity plan that provides hospitalization benefits only, or one that also addresses diagnostic procedures, outpatient surgery and ambulance transportation, Aflac can help.

Specified Health Event / Heart Attack Plan

If a covered health event happens, you'll welcome cash benefits to help pay for items not covered by your major medical insurance plan, including the numerous out-of-pocket expenses you'll face. A serious health condition such as heart attack, end-stage renal failure or third-degree burns is not only a life-altering physical event, but a devastating financial one as well. Specified Health Event insurance may make all the difference by providing cash benefits as you concentrate on your recovery.

Dental Plan

Before your dentist sends your next appointment-reminder card, apply for a plan that may help pay for the visit! After all, you are going to the dentist for routine and preventive care, so why not have a dental plan that pays directly toward those periodic checkups and cleanings—in a fast and painless way. In fact, a thorough examination, including X-rays, is all it usually takes to diagnose a problem. If you've been going to the dentist regularly (or need an incentive to begin), Aflac's plan offers some of the finest in easy-to-understand, choice-based coverage. Here's what they mean:

- The plan spells out the benefits for both wellness and other diagnostic/treatment services. There are no gray areas. Each covered procedure has a specific benefit amount with a specific waiting period.
- There's no deductible.
- You choose your dentist. Virtually all managed-care plans require you to use only dentists in their approved network. Aflac gives you total freedom to choose your own dentist without restriction.

- They pay benefits regardless of any other plan. Aflac pays full policy benefits, period! It doesn't matter if you have other dental or medical coverage that may overlap.

Pet Insurance (Available through Pet Best Insurance)

The next time you're faced with an unexpected vet bill, you won't have to worry about borrowing money, using high-interest credit cards or worse, choosing euthanasia because there's no help to pay the bill. With Pets Best on your side you can follow your veterinarian's recommend course of treatment without having to worry about breaking the bank.

You can insure your pet for less than $1 per day**!** Pets Best plans cover the treatment and diagnosis of accidents and illnesses. Your pet can see any licensed veterinarian in the world, and they have no upper age limits.

What Our Plans Cover		
Accidents	✓	Examples: broken bones, poisoning, car accident, lacerations, foreign object ingestion.
Illnesses	✓	Examples: cancer, diabetes, arthritis, allergies, cruciate ligament injuries, skin and ear infections, urinary tract infections, epilepsy, IVDD, cherry eye.
Emergency care, hospitalization & surgery	✓	See any licensed veterinarian, anywhere in the world, including emergency centers and specialists.
Hereditary and congenital conditions	✓	Examples: hip and elbow dysplasia, luxating patella, cherry eye, IVDD, Wobbler Syndrome, glaucoma and epilepsy.
Prescription medications	✓	See Our List by provided by your agent
Cancer treatments	✓	Including blood work, MRIs, surgery, medication, and chemotherapy.
Diagnostics	✓	Examples: exams, bloodwork, MRIs, CAT scans, pathology reports and X-rays.
Physical rehabilitation	✓	Examples: hydrotherapy, cold laser and physical therapy.

Please contact the City's Agent, Charlie Woodward (Good Circle Insurance), for Additional Information, Enrollment Appointment, Claims, and/or Questions:

Address: 23456 Madero Road, Suite 200 Mission Viejo, CA 92691
Cell#: 714-504-1964 Office#: 949-528-6604 Fax: 949-528-6605
Email: charlie@goodcircleinsurance.com

California Public Employees' Retirement System

The City contracts with the California Public Employees' Retirement System (CalPERS) for retirement plan administration. CalPERS administers defined benefit retirement plans for State employees, classified school employees, and employees of contracting local public agencies. These plans provide service retirement, disability, survivor, and death benefits to eligible employees and their beneficiaries and survivors. Most members become vested in the CalPERS retirement plan after five years of service.

In a defined benefit retirement plan, a retiree will receive a benefit determined by a set formula. The CalPERS defined benefit plans use the member's years of service, age at retirement, and highest three-year compensation while employed. Three sources fund a defined benefit retirement plan. First, employees make contributions based on a percentage of their earnings. The second source of funding is earnings from

the investment of CalPERS assets in stocks, bonds, real estate, and other investment vehicles. The balance of the funding is provided by employer contributions. The fiscal year 2017-2018 City employer contribution is 21.130%, which represents 10.446% for the normal cost and 10.684% for unfunded liabilities cost.

The service retirement formula for City employees hired before July 9, 2011 is the 2.7% at 55 formula. The service retirement formula for City employees hired after July 9, 2011 and a participant in a California public retirement system prior to January 1, 2013 is the 2% at 60 formula. Employees who are hired and first enter a public retirement system on or after January 1, 2013 are eligible for the 2% at 62 formula. These formulas provide 2% of the employee's highest three-year average compensation for each year of service at 60 (for 2% @ 60) or 62 (for 2% @ 62) years of age. Early retirement is permitted at progressively smaller percentages of compensation. Refer to the CalPERS Your Benefits Your Future publication for more detailed information and requirements.

Supplemental Health Account for Retired Employees (SHARE)

The Supplemental Health Account for Retired Employees (SHARE) became effective January 1, 2007. All employees that first became eligible for benefits on or after January 1, 2007, are required to participate in this program. SHARE is a defined contribution program for retiree health benefits that is intended to help retirees offset post-retirement health care costs by allowing them to contribute pre-tax dollars from their current wages with an additional contribution by the City. This program requires the employee to contribute 1.5% of their salary into an individual employee funded account. In addition, the City will contribute $100 per month for a full-time employee (pro-rated based upon the employee's actual full-time equivalency) into a City funded account. An employee must complete one year of service with the City prior to making their pre-tax contributions. This one year of service will be credited toward the 15 years of service requirement, but no employee or City contributions will be made during this first year.

A retiree shall become eligible for benefit disbursement on the first day of the month following retirement from the City, provided the employee is at least 55 years of age and had at least 15 years of service with the City. An employee who separates from City service prior to becoming an eligible retiree is entitled to the benefit disbursement from the employee funded account, but not the City funded account. Effective July 1, 2017, the plan is administered by ICMA-RC through their Retiree Health Savings (RHS) Plan.

Deferred Compensation

You may voluntary elect to establish and contribute to a 457(b) deferred compensation account. Both deferred compensation carriers, ICMA and Nationwide, offer 457(b) accounts. A 457(b) deferred compensation plan is a retirement plan offered by the City, created to allow public employees like you to put aside money from each paycheck toward retirement. A deferred comp plan can help bridge the gap between what you have in your pension and how much you'll need in retirement.

Federal and state income taxes are deferred until your assets are withdrawn, usually during retirement when you may be in a lower tax bracket.

The City will match your monthly deferred compensation contribution up to $150.00 per month regardless of your full-time equivalency (FTE). In order to receive the City's contribution, you must complete a 401(a) enrollment form with either ICMA or Nationwide. The City's matching contributions will go into the 401(a) account and not the 457(b) account.

What are the benefits of participating in a 457 plan?

- You reduce your current income taxes while investing for retirement.
- Your earnings accumulate tax-deferred.
- You participate in convenient payroll deductions.
- There are two "Catch-Up" provisions that allow you to contribute over-and- above the normal annual contribution amount.
- If you change jobs, you have the flexibility to move your account into your new Employer's retirement plan.
- Supplemental investments are helpful since no contribution is made to Social Security while working for the City of Mission Viejo.

Keep in Mind:

- There are strict Internal Revenue Code limits on the amount you may contribute each year.
- If you retire or leave service early, there are no penalties for withdrawals. However, you will be subject to taxes on the amount that you withdraw.
- You are required under IRS rules to begin withdrawing from the plan in the year you reach age 70½ or, if still working for the employer, in the year you retire, whichever occurs later.

Qualified retirement plans, deferred compensation plans and individual retirement accounts are all different, including fees and when you can access funds. Assets rolled over from your account(s) may be subject to surrender charges, other fees and/or a 10% tax penalty if withdrawn before age 59½.

Refer to your summary plan descriptions and/or our account representative for more detailed information and requirements.

COBRA Coverage

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

The Plan Administrator is City of Mission Viejo, Human Resources Division, 200 Civic Center, Mission Viejo, California 92691, (949) 470-3060. The Plan Administrator is responsible for administering COBRA continuation coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of health Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse or domestic partner and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

1. If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because of either of the following qualifying events:
    a. Voluntary or involuntary termination of your City of Mission Viejo employment (for any reason other than gross misconduct); or
    b. Reduction in hours of employment (including leave without pay).

2. If you are the spouse or domestic partner of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because of any one of the following qualifying events:
    a. Voluntary or involuntary termination of the employee's employment (for any reason other than gross misconduct);
    b. Reduction of hours worked by the employee (including leave without pay);
    c. Divorce, legal separation, annulment, or termination of domestic partnership of the employee; or

d. Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
e. Death of the employee.

3. Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because of any one of the following qualifying events:
    a. Voluntary or involuntary termination of the employee's employment (for any reason other than gross misconduct);
    b. Reduction of hours worked by the employee (including leave without pay);
    c. Divorce, legal separation, annulment, or termination of domestic partnership of the employee; or
    d. Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
    e. Death of the employee.
    f. Loss of dependent child status under the City's Group Insurance Regulations

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the City of Mission Viejo, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

COBRA continuation coverage will be offered to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. For each qualified beneficiary who elects COBRA continuation coverage, COBRA coverage will begin on the date that Plan coverage would otherwise terminate.

Notification Requirements

When the qualifying event is due to a divorce, legal separation, annulment, termination of domestic partnership or loss of dependent status, you (or the qualified beneficiary) must notify the Human Resources Division in writing within 30-calendar days of the qualifying event or the date coverage is lost, whichever is later. The following information must be included: name of the qualified beneficiary, the qualifying event, and the date of the qualifying event. Failure to provide written notice within the time limits can result in COBRA continuation coverage being forfeited. You must provide this notice to: City of Mission Viejo, Human Resources Division, 200 Civic Center, Mission Viejo, California 92691.

If your City employment ends or your work hours are reduced, the Human Resources Division will notify you of your right to elect COBRA continuation coverage. In the event of your death, the Human Resources Division will notify your qualified beneficiaries of their right to elect COBRA continuation coverage.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. You, your spouse or domestic partner may elect COBRA continuation coverage on behalf of any other qualified beneficiary. In addition, each qualified beneficiary will have an independent right to elect COBRA continuation coverage. This means each qualified beneficiary can elect independently to continue City-sponsored health coverage, even if you choose not to continue coverage under COBRA.

Length of COBRA Continuation Coverage

18-Month Period
The maximum COBRA continuation coverage period is 18-months for the following qualifying events:

- Voluntary or involuntary termination of your City of Mission Viejo employment (for any reason other than gross misconduct); or
- Reduction in hours (includes leave without pay)

Note: If the covered employee becomes entitled to Medicare (due to age) within 18-months before a termination of employment or reduction in hours, family members who are qualified beneficiaries may continue COBRA continuation coverage for up to 36-months. This period is counted from the date of the employee's Medicare entitlement.

36-Month Period

The maximum COBRA continuation coverage period is 36-months for the following qualifying events:

- Death of the employee;
- Divorce, legal separation, annulment or termination of domestic partnership; or
- Loss of dependent child status under the City's Group Insurance Regulations

Maximum Coverage Period under USERRA

The maximum COBRA continuation coverage period is 24-months for employees on military leave who are covered by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Extension of 18-Month COBRA Continuation Coverage

Disability

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage, and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11-months of COBRA continuation coverage, for a total maximum of 29-months. You are obligated to inform the Plan Administrator of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice must be sent to : **City of Mission Viejo, Human Resources Division, 200 Civic Center, Mission Viejo, California 92691.**

Second Qualifying Event

If your family experiences another qualifying event while receiving 18-months of COBRA continuation coverage, your spouse or domestic partner and dependent children may receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36-months, provided the notice of the second qualifying event is properly given to the Plan. This extension may be available to your spouse or domestic partner and any dependent children receiving continuation coverage if you (the employee or former employee) die, become divorced or legally separated, get an annulment, terminate a domestic partnership, or if your child loses dependent child status – but only if the event would have caused these individuals to lose coverage under the Plan had the first qualifying event not occurred. In all cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. The notice must be sent to : **City of Mission Viejo, Human Resources Division, 200 Civic Center, Mission Viejo, California 92691.**

CalCOBRA (AB 1401)

You and your qualified beneficiaries may be eligible to extend your medical plan coverage under CalCOBRA for up to a maximum of 36-months from the date of the beginning of your COBRA continuation coverage period if you have exhausted the 18-month or 29-month federal COBRA coverage period. This does not apply to City-sponsored dental and vision plans.

In order to exercise the continuation rights afforded under CalCOBRA, an election to purchase the extended coverage must be made in writing to the medical carrier no later than 30 calendar days prior to the end of the federal 18-month COBRA continuation period.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website).

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

City of Mission Viejo
Human Resources Division
200 Civic Center
Mission Viejo, CA 92691
(949) 470-3060
(949) 770-9926 FAX
www.cityofmissionviejo.org

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is provided to you in accordance with federal and state privacy laws enacted to protect your medical information. This notice describes the privacy practices of our health care carriers, third party administrators, and our plan as listed below, our legal duties, and your rights concerning your medical information.

Health care carriers, third party administrators, and our plan are required to follow the privacy practices that are described in this notice while it is in effect. However, health care carriers, third party administrators, and our plan reserve the right to change privacy practices and the terms of this notice at any time, provided that applicable law permits such changes.

If health care carriers and/or third party administrators make any substantive changes to their privacy practices, they will send you a new privacy notice within 60 days of the change in their practices.

If the City of Mission Viejo (City) makes any substantive changes to its privacy practices, the City will modify this notice and send you a new notice within 60 days of the change in the City's practices. You may request a copy of this notice at any time. For more information about the City's privacy practices, or for additional copies of this notice, please contact the City of Mission Viejo Human Resources Division.

This notice applies to the privacy practices of the health care carriers, third party administrators, and our plan as listed below:

HEALTH CARE CARRIERS	TYPE OF COVERAGE
Kaiser	Medical
Blue Shield of California	Medical
Anthem Blue Cross	Medical
Health Net	Medical
Sharp	Medical
United Healthcare	Medical
Delta	Dental
Vision Service Plan	Vision
THIRD PARTY ADMINISTRATOR	**TYPE OF COVERAGE**
Discovery	Flexible Spending Account

Uses and Disclosures of Your Medical Information

Health care carriers, third party administrators, and our plan are permitted to use or disclose your protected health information (PHI) for the following purposes:

Treatment: Health care carriers, third party administrators, and our plan may use and disclose your protected health information in order to assist your health care provider (doctors, hospitals, pharmacies, and others) in your diagnosis and treatment.

Payment: Health care carriers, third party administrators, and our plan use and disclose your protected health information to pay claims from doctors, hospitals and other providers for services delivered to you that are covered by your plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, or to be reimbursed by another entity that may be responsible for payment.

Health Care Operations: Health care carriers, third party administrators, and our plan use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service. In some cases, we may use or disclose your information for underwriting purposes, determining premiums, and the detection and investigation of fraud.

Other Permitted or Required Disclosures

Health care carriers, third party administrators, and our plan may also use or disclose your protected health information in support of:

As Required By Law: Health care carriers, third party administrators, and our plan must disclose protected health information about you when required to do so by law.

Plan Administration: To the plan sponsor, employer or other organization that sponsors your group health plan, to permit the plan sponsor to perform plan administration functions, as described in your plan documents.

Public Health Activities: Health care carriers, third party administrators, and our plan may disclose protected health information to public health agencies for reasons such as prevention or controlling disease, injury or disability.

Business Associates: To persons who provide services to us and assure health care carriers, third party administrators, and our plan that they will comply with privacy regulations and our procedures on the use of protected health information.

Law Enforcement: Health care carriers, third party administrators, and our plan may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

Research: Under certain circumstances, health care carriers, third party administrators, and our plan may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.

Special Government Functions: Health care carriers, third party administrators and our plan may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.

Judicial and Administrative Proceedings: Health care carriers, third party administrators, and our plan may disclose protected health information in response to a court or administrative order. Health care carriers, third party administrators, and our plan may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.

Industry Regulation: Health care carriers, third party administrators, and our plan may disclose you protected health information to state insurance departments, the U.S. Department of Labor and other government agencies, for activities authorized by law.

Workers' Compensation: Health care carriers, third party administrators, and our plan may disclose protected health information to the extent necessary to comply with state laws for workers' compensation programs.

Coroners, Funeral Directors, Organ Donation: Health care carriers, third party administrators, and our plan may disclose the protected health information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

Other Uses or Disclosures With An Authorization

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the plan.

Your Rights Regarding Your Protected Health Information

Right To Access Your Protected Health Information: You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. Health care carriers, third party administrators, and/or our plan may charge a fee for the costs of producing, copying and mailing your requested information, but we will inform you of the cost in advance.

Right To Amend Your Protected Health Information: If you feel that protected health information maintained by the health care carriers, third party administrators, and/or our plan is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. Health care carriers, third party administrators, and our plan may deny your request if, for example, you ask to amend information that was not created by the health care carriers, third party administrators, or our plan, as is often the case for health information in our records, or you ask to amend a record that is already accurate and complete.

If health care carriers, third party administrators, and/or our plan deny your request to amend, you will be notified in writing. You then have the right to submit to the health care carriers, third party administrators, and/or our plan a written statement of disagreement with our decision and the health care carriers, third party administrators, and/or our plan have the right to rebut that statement.

Right to an Accounting of Disclosures by the Plan: You have the right to request an accounting of disclosures health care carriers, third party administrators, and our plan have made of your protected health information. The list will not include disclosures related to your treatment, or payment, or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). Health care carriers, third party administrators, and our plan, may charge for providing the accounting disclosures, but we will inform you of the cost in advance.

Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information: You have the right to request that health care carriers, third party administrators, and our plan restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. We may not agree to your request. If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

Right To Receive Confidential Communications: You have the right to request that health care carriers, third party administrators, and our plan use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request

to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.

Contact Information for Exercising Your Rights: You may exercise any of the rights described above by contacting the City of Mission Viejo Human Resources Division.

Health Information Security

Health care carriers, third party administrators, and our plan require our employees and business associates to follow the Company's security policies and procedures that limit access to health information about members to those employees and or entities that need it to perform their job responsibilities. In addition, we maintain physical, administrative and technical security measures to safeguard your protected health information.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the health care carriers, third party administrators, and/or our plan and/or with the Secretary of the Department of Health and Human Services. All complaints to the health care carriers, third party administrators, and our plan, must be made in writing and sent to the address listed below:

CARRIER/TPA/PLAN	REQUEST FOR ACCOUNTING	RECORD OF DISCLOSURES	FILING A COMPLAINT	QUESTIONS
City of Mission Viejo	City of Mission Viejo 200 Civic Center Mission Viejo, CA 92691 Attn: Privacy Officer (949) 470-3060			
Discovery	Discovery Benefits, Inc. PO Box 2926 Fargo, ND 58108-2926 Attn: Privacy Officer/HIPAA Coordinator			
Kaiser	Director, Health Information Management Kaiser Permanente Baldwin Park Medical Center 1011 Baldwin Park Boulevard Baldwin Park, CA 91706		Call Member Service Call Center 1-800-464-4000 or (TTY) 1-800-777-1370	
Blue Shield of California	Blue Shield of California Privacy Official P.O. Box 272540 Chico, CA 95927-2540 Telephone: (888) 266-8080 Fax: (888) 201-9020 E-mail: blueshieldca_privacy@blueshieldca.com			
Anthem Blue Cross	Contact the HIPAA Coordinator at (888) 225-7377			
Delta Dental	Subscriber Services P.O. Box 7736 San Francisco, CA 91420 (877) 335-8273			
VSP	Contact Member Services department at (800) 877- 7195			HIPAA Coordinator (800) 852-7600, x4540

Active Employee Premium Schedule –Effective January 1, 2018

MEDICAL – Orange, San Diego, or Riverside County Residents *(Verify service area of each provider)*			
CARRIER	**EMP ONLY**	**EMP & 1**	**EMP & 2**
(AS) Anthem Select HMO	$659.69	$1,319.38	$1,715.19
(AT) Anthem Traditional HMO	$735.08	$1,470.16	$1,911.21
(BSA) Blue Shield Access+ HMO	$695.97	$1,391.94	$1,809.52
(HNSM) Health Net Salud y Mas HMO	$461.56	$923.12	$1,200.06
(HNSC) Health Net SmartCare HMO	$607.68	$1,215.36	$1,579.97
(KS) Kaiser	$666.80	$1,333.60	$1,733.68
(SHP) Sharp HMO *(San Diego County Only)*	$618.14	$1,236.28	$1,607.16
(UH) United Healthcare HMO	$616.66	$1,233.32	$1,603.32
(PCH) PERS Choice PPO	$698.96	$1,397.92	$1,817.30
(PS) PERS Select PPO	$654.74	$1,309.48	$1,702.32
(PC) PERS Care PPO	$733.50	$1,467.00	$1,907.10
MEDICAL – Los Angeles or San Bernardino County Residents (Verify service area of each provider)			
CARRIER	**EMP ONLY**	**EMP & 1**	**EMP & 2**
(AS) Anthem Select HMO	$660.17	$1,320.34	$1,716.44
(AT) Anthem Traditional HMO	$784.72	$1,569.44	$2,040.27
(BSA) Blue Shield Access+ HMO	$613.29	$1,226.58	$1,594.55
(HNSM) Health Net Salud y Mas HMO	$404.32	$808.64	$1,051.23
(HNSC) Health Net SmartCare HMO	$577.15	$1,154.30	$1,500.59
(KS) Kaiser	$642.70	$1,285.40	$1,671.02
(UH) United Healthcare HMO	$602.78	$1,205.56	$1,567.23
(PCH) PERS Choice PPO	$620.39	$1,240.78	$1,613.01
(PS) PERS Select PPO	$573.21	$1,146.42	$1,490.35
(PC) PERS Care PPO	$673.73	$1,347.46	$1,751.70
DENTAL & VISION – All Counties			
CARRIER	**EMP ONLY**	**EMP & 1**	**EMP & 2**
(DHMO) Delta Care	$23.47	$42.12	$62.73
(DPPO) Delta Preferred	$66.90	$118.70	$195.30
(VIS) Vision	$26.14	$41.03	$69.78
FLEXIBLE SPENDING ACCOUNTS		**ANNUAL MINIMUM**	**ANNUAL MAXIMUM**
(DEP CARE) Dependent Care Reimbursement		$300	$5,000
(MED REIMB) Medical Reimbursement		$180	$2,500
DEFERRED COMPENSATION		**ANNUAL MINIMUM**	**ANNUAL MAXIMUM**
Basic Annual Employee Contribution Levels		$120	$18,500
Age 50 or Older Catch-Up Contribution Levels		$0	$6,000

Fixed Monthly Employer Contribution Towards Employee Benefits – 01/01/2018

TIER 1 MONTHLY CITY CONTRIBUTION	
FULL-TIME EQUIVALENCY (FTE)	**OPT OUT**
1.000 (40 hrs/wk)	$975.00
.750 to .999 (30 – 39 hrs/wk)	$731.25
.500 to .749 (20 – 29 hrs/wk)	$487.50

TIER 2 MONTHLY CITY CONTRIBUTION TO EMPLOYEE HEALTH BENEFITS				
FULL-TIME EQUIVALENCY (FTE)	**MEDICAL PLAN ENROLLMENT LEVEL**			
	OPT OUT	**Employee Only**	**Employee + 1**	**Employee + Family**
1.000 (40 hrs/wk)	$750.00	$975.00	$1,062.00	$1,264.00
.750 to .999 (30 – 39 hrs/wk)	$512.50	$731.25	$796.50	$948.00
.500 to .749 (20 – 29 hrs/wk)	$275.00	$487.50	$531.00	$632.00

TIER 4 MONTHLY CITY CONTRIBUTION TO EMPLOYEE HEALTH BENEFITS				
FULL-TIME EQUIVALENCY (FTE)	**MEDICAL PLAN ENROLLMENT LEVEL**			
	OPT OUT	**Employee Only**	**Employee + 1**	**Employee + Family**
1.000 (40 hrs/wk)	$450.00	$1,120.00	$1,493.00	$1,700.00
.750 to .999 (30 – 39 hrs/wk)	$312.50	$840.00	$1,119.75	$1,275.00
.500 to .749 (20 – 29 hrs/wk)	$175.00	$560.00	$746.20	$850.00