

CITY OF MISSION VIEJO



**MISSION
VIEJO**

Make Living Your Mission

*Summary
of
Benefit
Plans -
2023*

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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.

Carrier Information At-A-Glance

Plan Name	Administrator	Plan Information
Anthem Blue Cross (HMO) <ul style="list-style-type: none"> Select HMO Traditional HMO 	Anthem Blue Cross (855) 839-4524	OptumRx is the Pharmacy Benefit Manager (PBM) providing prescription benefits for this health plan.
Blue Shield of California (HMO) <ul style="list-style-type: none"> Blue Shield Access+ HMO Blue Shield Trio HMO 	Blue Shield of California (800) 334-5847	Blue Shield of California administers their own prescriptions.
Health Net of California (HMO) <ul style="list-style-type: none"> Salud y Más HMO SmartCare HMO 	Health Net of California (888) 926-4921	OptumRx is the Pharmacy Benefit Manager (PBM) providing prescription benefits for this health plan.
Kaiser (HMO)	Kaiser Permanente (800) 305-1220	Kaiser administers their own prescriptions.
PERS Platinum (PPO)	Anthem Blue Cross (877) 737-7776	This plan has no geographical restrictions. It provides coverage anywhere in the world. OptumRx is the Pharmacy Benefit Manager (PBM) providing prescription benefits for this health plan.
PERS Gold (PPO)	Anthem Blue Cross (877) 737-7776	OptumRx is the Pharmacy Benefit Manager (PBM) providing prescription benefits for this health plan.
Sharp Health Plan (HMO) <ul style="list-style-type: none"> Sharp Performance Plus 	Sharp Health Plan (855) 995-5004	OptumRx is the Pharmacy Benefit Manager (PBM) providing prescription benefits for this health plan.
UnitedHealthcare (HMO) <ul style="list-style-type: none"> UnitedHealthcare SignatureValue Alliance UnitedHealthcare SignatureValue Harmony 	UnitedHealthcare (877) 359-3714	OptumRx is the Pharmacy Benefit Manager (PBM) providing prescription benefits for this health plan.

Plan Name	Administrator	Plan Information
<p>Aflac</p> <ul style="list-style-type: none"> • Cancer Protection Assurance • Accident Advantage • Critical Care Protection • Hospital Confinement 	<p>Aflac (800) 992-3522</p> <p>*CLOSED TO NEW ENROLLEES</p>	<p>Our Aflac representative is Jim Boada. He can be reached at (949) 872-1401 or via email at james_boada@us.aflac.com.</p> <p>*CLOSED TO NEW ENROLLEES</p>
<p>CalPERS</p> <ul style="list-style-type: none"> • Retirement 	<p>CalPERS (888) 225-7377</p>	<ul style="list-style-type: none"> • Service credit is the time you accrue while on the job under a CalPERS-covered employer. • Your retirement benefits are based on a formula - not what you contribute into the system. • Member Informational Videos
<p>Delta</p> <ul style="list-style-type: none"> • Delta Dental PPO • DeltaCare USA 	<p>Dental PPO (888) 335-8227</p> <p>DeltaCare USA (800) 422-4234</p>	<p>Dental PPO Group Number</p> <ul style="list-style-type: none"> • 10535-0001 <p>DeltaCare Plan</p> <ul style="list-style-type: none"> • CA10 A
<p>MHN</p> <ul style="list-style-type: none"> • Employee Assistance Program 	<p>MHN (800) 242-6220</p> <p>The online access code is missionviejo</p>	<ul style="list-style-type: none"> • Cope with grief, anxiety, stress, depression and other emotional health issues • Solve financial, legal, childcare and eldercare issues
<p>Nationwide Retirement Solutions</p> <ul style="list-style-type: none"> • 457(b) • 401(a) • Roth IRA 	<p>Nationwide (800) 769-4457</p> <p>Contact our Nationwide Retirement Specialist: Doug Rhyu (714) 504-8312 rhyud@nationwide.com</p>	<ul style="list-style-type: none"> • A deferred comp plan can help bridge the gap between what you have in your pension and how much you'll need in retirement. • The City will match your monthly 457(b) deferred compensation contribution up to \$150.00 per month.
<p>Voya Financial</p> <ul style="list-style-type: none"> • Group Term Life Insurance • Short-term Disability • Long-term Disability 	<p>(800) 955-7736</p> <p>To file a Claim</p>	<p>Life Insurance Policy</p> <ul style="list-style-type: none"> • 31640-7GAT • Public Risk Innovation, Solutions and Management ("PRISM") <p>Disability Policy</p> <ul style="list-style-type: none"> • 31640-7DISABILITY • Public Risk Innovation, Solutions and Management ("PRISM")
<p>Vision Service Plan (VSP)</p>	<p>VSP (800) 877-7195</p>	<p>VSP Signature Provider Network</p>
<p>Wex</p> <ul style="list-style-type: none"> • Medical FSA • Dependent Care FSA 	<p>Wex (866) 451-3399</p>	<p>Live Chat customerservice@wexhealth.com</p>

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 listed on the City's [website](#).

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
- ❖ 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
- ❖ Parents or Parent-in-laws
- ❖ Grandparents
- ❖ Stepchildren of former spouses*

*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).

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 Health Benefit Summary publication on the [CalPERS website](#) 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 Health Program Guide on the [CalPERS website](#) 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.

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

Enrolling in VSP Vision Care can save you money and helps keep your family happy and healthy. Keep your comprehensive vision care benefit and continue to get access to quality eye care and eyewear from an in-network doctor you'll love, all at low out-of-pocket costs.

- Value and savings you love. VSP members save on eyewear and eye care with a VSP network doctor. You'll also receive access to Exclusive Member Extras that can save you more than \$3,000. [Calculate your savings](#) and check out the [Exclusive Member Extras](#) you'll get.
- Provider choices you want. Most members have access to five VSP network doctors within six miles of where they live or work. It's easy to [find a nearby in-network doctor](#) to maximize your vision coverage.
- See better. Look your best. VSP members have access to a huge selection of designer brand frames. From classic styles to the latest designer frames, you'll find a great selection of eyewear for you and your family at an eye care provider near you.

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. You can access your accounts anytime, anywhere, by using the [mobile app](#). Both types of accounts are administered through [Wex](#). An [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 \$3,050, pre-tax, annually to this account. You can also receive and use a benefit debit card. There are thousands of eligible procedures, items and expenses based on your plan. View the interactive list of eligible expenses.

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. 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 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 \$100,000, 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 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 [Short-term 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 [Long-term 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).

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 service retirement formula for City employees hired before July 9, 2011, is the 2.7% at 55 formula and employees contribute 9.5% towards this benefit. 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 and employees contribute 8.5% towards this benefit. 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 and contribute 9% towards this benefit effective July 1, 2023. 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 MissionSquare through their Retiree Health Savings (RHS) Plan.

Deferred Compensation

You may voluntarily elect to establish and contribute to a 457(b) deferred compensation account. [Nationwide](#) offers a pre-tax 457(b) account as well as a post-tax Roth 457 account. 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.

For the pre-tax 457 account, federal and state income taxes are deferred until your assets are withdrawn, usually during retirement when you may be in a lower tax bracket. When you choose to make Roth 457(b) contributions, you’ll pay taxes upfront when your money goes into the plan. Then you’ll enjoy tax-free

withdrawals — as long as you're at least 59½, and do not take withdrawals from your Roth account for at least five years after your first Roth contribution is made to the plan.

You can choose to allocate part or all of your salary deferral to the Roth or all or part of your salary deferral to your traditional 457(b) pre-tax account.

The City will match your monthly 457(b) 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 Nationwide 401(a) enrollment form. 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 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.
- 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.

Contact our Nationwide account representative for more detailed information and requirements:
Douglas Rhyu 714-504-8312 rhyud@nationwide.com

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
hrnotifications@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
Anthem Blue Cross	Medical
Blue Shield of California	Medical
Delta	Dental
Health Net	Medical
Kaiser	Medical
Optum RX	Pharmacy
Sharp	Medical
United Healthcare	Medical
Vision Service Plan	Vision
THIRD PARTY ADMINISTRATORS	TYPE OF COVERAGE
CalPERS	Medical Plan Administration
BCC	Dental Plan Administration
Wex	Flexible Spending Account Administration

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
Anthem Blue Cross	Call Member Services at the toll-free number on the back of your ID card. Write to the Privacy Office at: CO0109-0903, 700 Broadway, Denver, CO 80273. Email the Privacy Office at Privacy.Office@anthem.com .			
Blue Shield of California	Call the Blue Shield Privacy Office at (888) 266-8080 (toll free). Write to the Blue Shield Privacy Office at: P.O. Box 272540, Chico, CA 95927-2540. Email the Privacy Office at privacy@blueshieldca.com .			

City of Mission Viejo	Call the Privacy Officer at (949) 470-8416. Write to the Privacy Officer at 200 Civic Center, Mission Viejo, CA 92691.
Delta Dental	You may contact Delta Dental at 866-530-9675, or you may write to the address listed below for further information about the complaint process or any of the information contained in this notice. Delta Dental P.O. Box 997330 Sacramento, CA 95899-7330
HealthNet	Health Net Privacy Office Attn: Privacy Official P.O. Box 9103 Van Nuys, CA 9140 Telephone: 1-800-522-0088 Fax: 1-818-676-8314 Email: Privacy@healthnet.com
Kaiser	By phone: Call member services at 1-800-464-4000 (TTY 711) 24 hours a day, 7 days a week (except closed holidays). By mail: Call us at 1-800-464-4000 (TTY 711) and ask to have a form sent to you. In person: Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses) Online: Use the online form on our website at kp.org
Sharp	Please call or write at: Privacy Officer, Sharp Health Plan, 8520 Tech Way, Ste. 200, San Diego, CA 92123-1450 (1-800-359-2002).
United Healthcare	Please call the toll-free member phone number on your health plan ID card or you may contact a UnitedHealth Group Customer Call Center Representative at 1-866-633-2446. Submitting a Written Request. You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting copies of your records, or requesting amendments to your record, to us at the following address: UnitedHealthcare Customer Service -Privacy Unit PO Box 740815 Atlanta, GA 30374-0815
VSP	Submit your requests to: VSP Attn: Regulatory Compliance 3333 Quality Drive MS-163 Rancho Cordova, CA 95670 HIPAA@vsp.com
Wex	Email: privacy@wexinc.com Mail: WEX, Inc. c/o Privacy 97 Darling Avenue South Portland, ME USA 04106

Active Employee Premium Schedule – Effective January 1, 2023

MEDICAL REGION 2 – Orange and San Diego County Residents <i>(Verify service area of each provider)</i>			
(Munis Carrier Code) CARRIER NAME	EMP ONLY	EMP & 1	EMP & 2 or More
(AS) Anthem Blue Cross Select	\$765.37	\$1,530.74	\$1,989.96
(AT) Anthem Blue Cross Traditional	\$935.12	\$1,870.24	\$2,431.31
(BSA) Blue Shield Access+	\$842.61	\$1,685.22	\$2,190.79
(BST) Blue Shield Trio	\$760.71	\$1,521.42	\$1,977.85
(HNSM) Health Net Salud y Mas	\$698.91	\$1,397.82	\$1,817.17
(HNSC) Health Net SmartCare	\$834.65	\$1,669.30	\$2,170.09
(KS) Kaiser Permanente	\$756.21	\$1,512.42	\$1,966.15
(PGB) PERS Gold PPO	\$695.93	\$1,391.86	\$1,809.42
(PPB) PERS Platinum PPO	\$1,014.80	\$2,029.60	\$2,638.48
(SHRP) Sharp <i>(San Diego County Only)</i>	\$764.96	\$1,529.92	\$1,988.90
(UH) UnitedHealthcare Signature Alliance	\$793.63	\$1,587.26	\$2,063.44
(UHH) UnitedHealthcare Signature Harmony	\$781.58	\$1,563.16	\$2,032.11
MEDICAL REGION 3 – Los Angeles, Riverside, and San Bernardino County Residents <i>(Verify service area of each provider)</i>			
(Munis Carrier Code) CARRIER NAME	EMP ONLY	EMP & 1	EMP & 2 or More
(AS) Anthem Blue Cross Select	\$737.91	\$1,475.82	\$1,918.57
(AT) Anthem Blue Cross Traditional	\$942.73	\$1,885.46	\$2,451.10
(BSA) Blue Shield Access+	\$738.29	\$1,476.58	\$1,919.55
(BST) Blue Shield Trio	\$661.49	\$1,322.98	\$1,719.87
(HNSM) Health Net Salud y Mas	\$606.34	\$1,212.68	\$1,576.48
(HNSC) Health Net SmartCare	\$755.29	\$1,510.58	\$1,963.75
(KS) Kaiser Permanente	\$754.64	\$1,509.28	\$1,962.06
(PGB) PERS Gold PPO	\$680.37	\$1,360.74	\$1,768.96
(PPB) PERS Platinum PPO	\$992.59	\$1,985.18	\$2,580.73
(UH) UnitedHealthcare Signature Alliance	\$790.46	\$1,580.92	\$2,055.20
(UHH) UnitedHealthcare Signature Harmony	\$713.55	\$1,427.10	\$1,855.23
DENTAL & VISION – All Counties			
(Munis Carrier Code) CARRIER NAME	EMP ONLY	EMP & 1	EMP & 2 or More
(DHMO) Delta Care	\$19.40	\$34.60	\$51.00
(DPPO) Delta Preferred	\$66.30	\$117.60	\$193.40
(VIS) Vision	\$26.14	\$41.03	\$69.78
FLEXIBLE SPENDING ACCOUNTS		ANNUAL MINIMUM	ANNUAL MAXIMUM
Dependent Care Reimbursement		\$300	\$5,000
Medical Reimbursement		\$180	\$3,050
DEFERRED COMPENSATION		ANNUAL MINIMUM	ANNUAL MAXIMUM
Basic Annual Employee Contribution Levels		\$120	\$22,500
Age 50 or Older Catch-Up Contribution Levels		\$0	\$7,500
Pre-Retirement Catch-Up Contribution Levels		\$0	\$22,500

Fixed Monthly Employer Contribution Towards Employee Benefits – 07/01/2023

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	\$1,843.00	\$2,050.00
.750 to .999 (30 – 39 hrs/wk)	\$312.50	\$840.00	\$1,382.25	\$1,537.50
.500 to .749 (20 – 29 hrs/wk)	\$175.00	\$840.00	\$1,382.25	\$1,537.50