



Flexible Benefits Plan

Summary Highlights

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IMPORTANT: This handbook contains brief descriptions of all the benefit options covered under the Flexible Benefits Plan program. Please keep in mind that this material is a summary of legal plan documents. Should there be a disagreement between this handbook and the legal plan documents governing the program, the legal plan documents will control.

Information regarding your benefit options are available in other forms of communications for visually and/or hearing impaired employees. Contact Flexible Benefits at (619) 236-5924 for more details.

BENEFITS ELIGIBILITY

What Benefits Does The City Offer?

The City has a Flexible Benefits Plan program for its benefited employees.

What Is The Flexible Benefits Plan Program?

The Flexible Benefits Plan program is a cafeteria style benefits program regulated by the IRS, Section 125 rules and regulations. This plan program allows employees to choose the benefit plan coverage tailored to his/her family needs. The health plan premiums can be deducted on a pre-tax basis to allow the employee to reduce his/her taxable wage for income tax purposes.

Who Is Eligible For The Flexible Benefits Plan Program?

City employees that meet **ALL** of the following criteria listed below are eligible:

- Active
- Classified or Unclassified
- Hourly or Salaried
- Permanent or Limited
- Entitled to Annual Leave Hours
- Standard Working Hours - 40, 60, 80 or 112

Does The City require An Employee To Enroll For All The Benefit Plans?

No. The City only requires an employee to enroll for a Basic Life Insurance and Medical Insurance.

What If I Have Medical and/or Life Insurance Outside The City, Am I Still Required To Enroll For Both Plans?

The City wants to make sure that its benefited employees have medical and life insurance coverage at all times.

You are allowed to *waive* the Medical insurance provided it is a *comprehensive* plan. You are *not* allowed to Waive Medical Insurance if you have Medi-Cal coverage.

The Basic Life insurance is *required* even if you have other coverage. The amount of Basic Life insurance and how much it will cost you is determined by your job classification. See the Life Insurance section for more information.

FLEXIBLE BENEFITS PLAN PROGRAM

How Does The Flexible Benefits Plan Program Work?

The City provides each benefited employee an amount of money called **City FBP Credit** on a *biweekly* basis as long as the employee *works* or is in a “Paid” leave status of at least **40 hours** in a pay period.

The **City FBP Credit** is added as a “taxable” *Earning* on the employee’s paycheck.

When you enroll for medical, dental, vision, basic life insurance, dental/medical/vision reimbursement and/or dependent care reimbursement the “full” *biweekly cost* is deducted from your paycheck as “Pre-Tax” deductions.

The amount of the City FBP credit and the costs for insurance are shown in the appendices beginning on page 53.

What Does Pre-Tax Mean?

Pre-tax means that the biweekly cost of benefits that are deducted from your paycheck *reduces* your reportable “taxable” *Earnings*. When your total taxable earning is reduced, it also reduces your total deduction for Federal and State taxes. This means you have *more* money to take home.

NOTE: If your benefit premiums are deducted on a pre-tax basis, you are *not* allowed to claim the benefit premiums as an expense on your personal income tax return because the premiums have already reduced your taxable wage at the end of the calendar year.

How Soon Am I Entitled To Receive The City FBP Credit?

As a newly eligible benefited employee, you are entitled to the City FBP Credit on the *first day of the pay period following date of hire or becoming a benefited employee*.

If you were hired at the beginning of the pay period and worked at least **40 hours** on the first pay period you become eligible for benefits, you are entitled to receive the *full* City FBP Credit for that pay period.

How Much City FBP Credit Do I Get On A Biweekly Basis?

Before the City’s Fiscal Year begins (July 1), each employee association (union) that represents the City’s various classifications meet to negotiate with the City negotiating team the benefit plans and City FBP Credits for the following fiscal year.

The City FBP Credit you’re entitled to depends on the following:

- Employee Group your classification is represented by;
- Your Standard Working Hours (40, 60, 80 or 112);
- Medical plan coverage:
 - Waive Medical coverage;
 - Employee only;
 - Employee and Spouse/Domestic Partner;
 - Employee and Child(ren)
 - Employee and Spouse/Domestic Partner and Children

Please refer to “Appendix A” at the back of this brochure for your annual and biweekly City FBP Credit.

Do I Get The Same City FBP Credit On A Biweekly Basis?

MEA and Local 911 Classified employees receive the same City FBP Credit for the entire fiscal year.

Local 127 Classified employees receive less City FBP Credit if they gain medical coverage any time during the fiscal year and elect to waive their medical coverage at that time. They receive an increase in City FBP Credit if they enroll for medical coverage.

POA, Local 145, DCAA, Unrepresented and Unclassified employees receive the same City FBP Credit on a biweekly basis *unless* one of the following employment or life event changes occur within the fiscal year:

- Change in Classification (i.e. Unrepresented to MEA or Local 127 to MEA, etc.)
- Change in Standard Working Hours (i.e. 80 to 40 or 40 to 80, etc.)
- Add or delete dependent(s) due to qualifying event.

In the case of an FBP Credit change, it will take effect the first of the pay period following the qualifying event. If adding a dependent(s) this will result in you having to pay the additional premiums since the coverage is paid in advance.

What Is A “Qualifying Event” ?

Per IRS regulations, an employee is allowed to change benefits enrollment or plan selection if there’s a qualifying event:

- Marriage
- Divorce
- Birth or Adoption
- Gain Coverage due to Employment
- Lose Coverage due to Termination
- Court Order
- Reduction in work hours
- Death of dependent
- Overage dependent

The Plan will also allow a HIPAA special enrollment for employees and dependents (including domestic partners, civil union partners or same sex spouses) who are eligible but not enrolled if they lose Medicaid or CHIP coverage because they are no longer eligible, or they become eligible for a state’s premium assistance program. Employees have sixty (60) days from the date of the Medicaid/CHIP event to request enrollment under the Plan. If you request this change, coverage will be effective the first of the month following your request for enrollment.

What Do I Do When I Have A Qualifying Event?

If you have a qualifying event or know that you will have a qualifying event, you **must** contact a Benefits Representative at the Risk Management Department, Flexible Benefits Plan Section at (619) 236-5924 within **30 days** from the date of qualifying event if you want to add or delete dependents to your health (medical, dental or vision) plans or change benefit selections.

Notification to or from the carriers, including temporary membership cards for newborns, does not mean the change is done. You must provide the supporting documents (birth certificate, marriage certificate, proof of loss of coverage) to Risk Management and make the change on ESS before your dependents will be added.

If you **miss** the 30-day deadline, you will only be allowed to make the change during open enrollment for the following fiscal year’s benefit enrollment.

What Happens If I Did Not Work or Was Not In A Paid Status For At Least 40 Hours In A Pay Period?

You are **not** entitled to the City FBP Credit if you did **not** work or you don’t have “paid” leave of at least **40 hours**.

Depending on the amount of your paycheck for that pay period you may not have enough earnings to pay for your benefit deductions. If this happens, a Benefits Representative will send you a letter to your home address to ask if you wish to continue to pay for your insurance premiums.

If you do not pay, your coverage will be cancelled and will not start again until you have paid for the upcoming month’s coverage. Contact Benefits staff at 619-236-5924 should this occur so you know when your coverage will resume.

What Is A “PAID” Leave?

The City will continue to provide you the City FBP Credit to pay for your health insurance benefits as required by law or City policy if you’re in the following “paid” leave:

- Annual/Sick Leave (minimum 40 hours per pay period)
- Long-Term Disability (1 year)
- Family Medical Leave (FMLA)** – 12 weeks maximum (except 26 weeks maximum in case of care of an injured military service person)
- Industrial Leave* - 2080 hours maximum
- Total Temporary Disability (TTD)* - 2080 hours maximum
- Military Leave – 30 day or presidential military leave
- Mandatory and/or Paid Voluntary Furlough

* Combined total for both

** Combined total for LTD, Industrial Leave, TTD and FMLA

FMLA/CFRA

If your absence qualifies under the Family Medical Leave Act (FMLA) or California Family Rights Act (CFRA) and you are eligible, you are entitled to City paid medical insurance for up to twelve weeks in a one year period (combined between both FMLA and CFRA). A special 26-week FMLA leave may also be available to care for an injured service person. To be eligible for FMLA you must have been employed with the City for at least twelve months and have worked 1,040 hours in the 12 month period and you must be on leave for your own serious medical condition, the birth or placement of your child within 12 months of occurrence, to care for an eligible family member with a serious medical condition, or to deal with a military exigency involving a family member who is called to active duty. You must submit a Family and Medical Leave Certification form signed by a physician to initiate your request. For more information on FMLA, eligibility and qualified absences visit the Resources and Tools tab of the Human Resources website on the City's intranet or contact your department payroll specialist.

What Happens if I Terminate and Get Rehired Within the Same Fiscal (Plan) Year?

If you terminate employment and are rehired within the same Plan year, your benefits prior to your termination will be reinstated. Unless you have a change in status you will not be allowed to change your benefits until the next open enrollment period.

If you have more questions about stopping or returning to work call the City's Flexible Benefits Plan section at 619-236-5924.

DEPENDENTS

Who Can I Enroll For Benefits?

A. Health (Medical, Dental or Vision) Plans

The following family members/dependents of an employee can be enrolled for health plans:

- Spouse
- Domestic Partner (same or opposite sex)
- Children*
- Adopted Children*
- Stepchildren
- Children of Domestic Partner*
- Children that are Court Ordered due to Legal Guardianship*

*Up to age 26

B. Portable Term Life Insurance Plans

The following family members/dependents of an employee can be enrolled on the health plans:

- Spouse
- Domestic Partner (same or opposite sex)
- Children*
- Adopted Children*
- Stepchildren*
- Children of Domestic Partner*

*Coverage up to age 19 or age 25 if full-time student.

C. Dental/Medical/Vision (FSA) Reimbursement

A dependent must meet the Code 105(b) Dependent requirement in order to be an employee's tax dependent for the flexible spending account.

A Code 105(b) dependent must meet most, but not all, of the requirements to be a qualified child or qualified relative:

- A qualifying child is an individual who: a) bears a specified relationship to the employee; b) has the same principal abode as the employee for more than half of the year; c) meets certain age requirements; d) has not provided more than half of his or her own support for the year; e) has not filed a joint tax return with his or her spouse for the year.

- A qualifying relative is an individual: a) who bears a specified relationship to the employee; b) whose gross income is less than the exemption amount; c) with respect to whom the employee provides over half of the individual's support; d) who is not anyone's qualifying child.

NOTE: A domestic partner and children of domestic partner **must** meet the qualifying relative requirement to be eligible for dental/medical/vision reimbursement.

D. Dependent Care Reimbursement

The family member/dependent that is eligible for dependent care under the City's plan is:

- your qualified child that meets Code 105(b) and younger than 13 years;
- a member of your immediate family who are physically or mentally incapable of caring for themselves
- a child or adult who you may claim an exemption for Federal income tax purposes.

Does The City Require Me To Submit Proof Of Relationship To Cover My Dependents For Benefits?

Yes.

What Does The City Require Me To Submit as Proof Of Relationship To Cover My Dependents For Benefits?

The City requires the following to be submitted in order to enroll dependents for benefits:

- Spouse – Marriage Certificate
- Domestic Partner – Notarized Affidavit of Domestic Partner Relationship or State Registration of Domestic Partner Relationship
- Children – Birth Certificate
- For qualified child or relative for FSA Dental Medical/Vision reimbursement - Federal Tax Return

Can I Have The Premium For My Domestic Partner Deducted On A Pre-Tax Basis?

Per IRS regulations, a domestic partner health insurance premium can be deducted on a “Pre” tax basis if the domestic partner meets ALL of the following requirements under IRS Code 105:

- Has the same principal place of abode as the employee and member of the employee’s household;
- Has gross income less than the exemption amount;
- Receives over half of his or her support from the employee;
- Is not anyone’s qualifying child;
- Is not an ineligible individual who files a married filing joint return;
- Is a U.S. citizen or resident alien in the United States

If not, a domestic partner’s health insurance premium must be deducted on a “Post” tax basis.

What Is The Maximum Age I Can Enroll My Dependent Children For Health Benefits?

You can enroll your qualified children under age 26. This maximum age is waived if the dependent is mentally or physically disabled (subject to approval by medical insurance provider).

Do I Need To Submit Any Documents To Prove That My Qualified Child Is Mentally Or Physically Disabled?

Yes. The medical documentation that you submit to Social Security to qualify a dependent for Social Security benefits is required.

BENEFITS ENROLLMENT PROCESS

What Happens On My First Day of Employment Or Become Eligible For Benefits?

Before you start working for the City or become eligible for benefits, your Payroll Specialist will do the following:

- Acquire your Login access to the City's Employee Self-Service system.
- Schedule you for the Benefits New Employee Orientation (Benefits Orientation).
- Provide you the benefits enrollment packets for the plans you can enroll for.

It is recommended that you *read, review and discuss* with your eligible family members the benefits materials *before* you attend the Benefits Orientation meeting. This way you are prepared to enroll for your benefits after you attend the Benefits Orientation meeting.

The Benefits enrollment can only be done using a City computer. You must enroll within **30 days** from the date you first become eligible for benefits enrollment. This is generally the date you begin working for the City or change to a benefited status. The longer you wait to enroll could affect the amount deducted from your paycheck once you enroll so it is in your best interest to enroll as soon as you can after becoming eligible.

What Is Discussed At The Benefits Orientation Meeting?

The Benefits Orientation meeting provides information about the following benefits:

- City Employees Retirement Plan Program
- Employee Savings Plan Programs
- Flexible Benefits Plan Program
- Employee Group Association Benefits

You will be assisted by each programs' staff members to complete the necessary application forms and answer any questions you may have regarding the benefits you're interested to sign up for.

What Do I Need To Bring To The Benefits Orientation Meeting?

The following documents are *required* for you to bring to the New Employee Orientation meeting:

- **Birth Certificate or Driver's License** to show proof of age for Retirement entry age benefit calculation.
- **Marriage Certificate or State Registration or Notarized Affidavit of Domestic Partner Relationship (if applicable)** – to provide proof of marital status for Retirement and Benefits enrollment.
- **Children's Birth Certificate** – to provide proof of relationship to enroll for children coverage in a benefit plan.
- **Court Ordered Documents** – to provide proof to cover eligible dependents for health insurance benefits.
- **Copy of Social Security card for each family member/dependent** – to verify the dependents' social security number for benefits and beneficiary enrollment. Qualified dependents *cannot* be enrolled for the health plans *without* social security number information.

What Do I Do Next After The Benefits Orientation Meeting?

After the Benefits Orientation, you will need to login to the OneSD Employee Self-Service (ESS) to enter your family member/dependent information and enroll for your benefits for the Flexible Benefits Plan.

Your Payroll Specialist or Risk Management Benefits Representative staff is available to assist you in the enrollment process through ESS.

INSURANCE AND FSA PAYMENTS

Can I Have The Pre-Payment For My Insurance Premium Deducted From My Paycheck?

You are allowed to have the pre-payment for your insurance premium deducted from your paycheck.

What If My Paycheck Is Not Enough To Pay For The Pre-Payment For My Insurance?

The total pre-payment can be divided into two pay periods. If the total pre-payment cost is more than the “Earning” for two pay periods and cannot be deducted on your paycheck, an invoice will be issued and mailed to you for payment.

How Do I Pay For My Insurance?

The *full* cost of insurance premium is deducted from your *biweekly* paycheck provided you receive an “Earning” enough to cover the cost of insurance.

NOTE: The City FBP Credit is reported as an “Earning” on your paycheck. If you work and/or on paid leave of *less* than 40 hours in a pay period, you are not entitled to receive the City FBP Credit for that pay period.

What Happens If I Do Not Have Enough “Earning” To Pay For My Insurance Premium?

You will receive a letter in the mail from a Benefits Representative asking if you wish to pay for your insurance coverage.

What Happens If I Elect To Pay For My Insurance Premium?

You are asked to return the letter that was sent to you, acknowledging your election of continuation of coverage. An *invoice* will be issued and mailed to you for payment.

NOTE: If you will be on a leave of absence without pay for an extended time, you will be enrolled in the COBRA plan and you may request an invoice be sent to you on a monthly basis until the month you plan to stay off work. Please refer to the Continuation of Coverage (COBRA) Section towards the back of this brochure.

What Happens If I Elect Not To Pay For My Insurance Premium?

Yours and your dependents’ insurance coverage will be canceled due to non-payment. It will be your responsibility to pay for the full cost of any medical, dental or vision services incurred during the cancellation period.

What Happens If My FSA Deduction Was Not Taken From My Paycheck?

The biweekly premium will automatically be adjusted for the remaining pay periods in the fiscal year.

If you allocated \$2,500 in the fiscal year, the biweekly deduction for 26 pay periods is \$96.15. If the FSA deduction was not taken for 6 pay periods, the contribution for 6 pay periods which amounted to \$576.90 will be added to the balance and calculated for the remainder of the year.

Please contact the Flexible Benefits Plan Section staff at (619) 236-5924 to discuss your options if you will be in this situation.

EMPLOYEE SELF-SERVICE (ESS)

What Is Employee Self-Service (ESS)?

Employee Self-Service (ESS) is an SAP Portal Page where employees can view or update their own personal record while working for the City. It is an integrated system so that the entry made to the main record is reflected in all Human Capital Management (HCM) modules (Personnel, Payroll and Benefits).

Where Do I Access The Employee Self-Service (ESS) System?

Access to the ESS portal page is only available through a City computer. Therefore, an employee has to be at work to access it.

How Do I Access the Employee Self-Service (ESS) System?

An employee is given a personal login id and temporary password before he/she can access the system that has the ESS system. The employee has to change the temporary password on his/her first login.

REMINDER: An employee is *prohibited* to provide his/her login id and password to anyone including supervisor, co-worker, payroll specialist, spouse or any relative working for the City. Providing your login id and password to anyone could result in *disciplinary action or termination of employment* with the City.

NOTE: Please *protect your password*. If you forget your password, you are only allowed 3 tries before the system cuts you off. When this happens, you will need to contact the IT Help Desk at x65999 or 1-877-796-5999 to reset your password.

Do I Need To Do Anything Before I Access the Employee Self-Service (ESS) System?

First, you need to gather the following information about your dependents to avoid logging in and logging off the ESS to complete the required dependent information:

- Name – Full name as shown on birth or marriage certificate.
- Birth Date
- Social Security number
- Address – if different from your address
- Medical and Dental doctors' name and medical group id number.

Second, if you are a new employee or need to change your benefits selection due to a qualified status change and would like to enroll your dependents for health benefits, you will need to contact the Flexible Benefits Plan Section at (619) 236-5924. The Benefits Representative will assist you to make your enrollment go smoothly. You will be asked when you wish yours and your dependents health insurance to take into effect. You may be required to submit the required documentation to allow you to change benefits selections due to a qualified status change.

What Do I See On The Employee Self-Service (ESS) Portal Page?

The ESS portal page has the following tabs:

- Time Management
- Payment
- Personal Information
- Benefits

By clicking these tabs, it will take you to the areas you can view and update.

Time Management

This is where you enter your daily working and leave time hours.

Payment

This is where you can view and print a copy of your paystubs.

Personal Information

This is where you can view and update the following information:

A. Personal Data - View access only.

To change any of the below items, the Personal Data form **must** be completed and submitted to Personnel, at MS # 51P.

- Name
- Social Security Number
- Gender
- Date of Birth
- Marital Status

B. Addresses – View and Change access

- **Permanent** – Address for Income Tax use.
- **Benefits** – Address for Health Insurance Providers to determine eligibility (within 30 miles from medical facility). **Cannot** use P.O. Box address.
- **Mailing** – Address for Official City mail. P.O. Box address is **allowed**.

C. Family Member/Dependents – View and Change access

To enroll family member/dependents for benefits or name someone as a beneficiary for life insurance and employee savings plans, you need to enter the following dependent information:

- Relationship of the family member or dependent – Select the appropriate relationship of your qualified dependent to you from the list.

NOTE: For a beneficiary not on the list, select “Other” Beneficiary

- Enter family member/dependent information. If you wish to **enroll** your family member/dependent to your health and life insurance plans, the following information is **required** by the insurance companies. The information you entered here is electronically loaded to the provider’s enrollment system which replaces the completion of insurance application forms for each insurance provider. **Incomplete** information could result in **issues** when your dependents obtain services.
- Name
- Date of Birth
- Gender
- Social Security Number
- Address
- Physician 1 Name – HMO Medical
- Physician 1 ID Number – HMO Medical
- Physician 2 Name – DHMO Dental
- Physician 2 ID Number – DHMO Dental

NOTE: Entering the dependent information does **not** automatically make a dependent eligible for health insurance benefits. Please refer to the Dependent section for qualified dependents.

To end a family member/dependent relationship, you will need to contact the Flexible Benefits Plan Section staff at (619) 236-5924 to stop the enrollment of the family member/dependent from any benefit plans.

Benefits Tab

Benefits Participation

- **Participation Overview link** – to view and print the following:
 - Current or Previous Selection Statement
 - Open Enrollment Benefits Worksheet Selection Statement
 - Confirmation Statement for Open Enrollment or any time changes

- **Benefit Enrollment** – to view and change benefits for the following:

- **Open Enrollment** – available during open enrollment period to change or enroll for the following plans:
 - Dental
 - Medical
 - Vision
 - Basic Life Insurance
 - FSA DMV Plan
 - FSA DCC Plan

- **Anytime Beneficiary** – available to change at any time
 - Life Insurance
 - Savings Plans – all plans except Retirement plan

- **Anytime Savings** – available to change the following savings plans at any time:
 - 401(k)
 - Deferred Compensation
 - 401(a) Voluntary, if eligible

- **Qualified Status Event** (Marriage, Divorce, Birth, Gain or Loss of Coverage, Rehire, Class/Org Change, etc.)
 - Medical
 - Dental
 - Vision
 - FSA DCC Plan

- **Flexible Spending Accounts** – To view account balance and enter claim/reimbursement
 - Dental/Medical/Vision
 - Dependent Child Care

LIFE INSURANCE

When Your Coverage Begins

If you are a new employee or have elected a new life insurance amount, your coverage or new amount will start the first of the month following when you physically report to the work site after July 1 of the benefit year.

When Your Coverage Ends

If you leave your job with the City before the fiscal year ends your coverage will end on the last day of the month in which you leave. Contact Flexible Benefits Plan Section at (619) 236-5924 if interested in continuing your policies upon termination.

If you are on an approved "Leave Without Pay" status, you may be eligible to continue your coverage by paying the required premium. Flexible Benefits staff will send you a letter asking if you want to continue your coverage. If you don't continue, your coverage will stop on the last day of the month in which you worked or don't pay your required premium.

What Kind of Coverage is Available

If you are represented by MEA, Local 911 or Local 127 you have a choice of three levels of Basic term insurance – \$10,000, \$25,000, \$50,000. You must select one of these options and pay for it through payroll deduction. The biweekly cost for each amount is shown in Appendix C.

If you are represented by POA, Local 145, DCAA or are Unrepresented or Unclassified you will receive \$50,000 of Basic term insurance at no cost to you.

The Basic term insurance includes Accidental Death and Dismemberment Insurance (AD&D). In case you die or are injured permanently, the policy may pay up to the amount of your Basic life insurance amount. An accelerated benefit is also available that provides up to half of the policy amount at the time you are diagnosed with a terminal illness.

Additional Life Insurance Available To You and Your Dependents

Portable term insurance allows for continuation of the policy at the City's group rates at time of

termination up to age 70. At age 70 you can convert to an individual policy. There are various levels of coverage from which to choose. You may increase the amount of portable coverage by one level without having to submit proof of good health up to \$250,000. Above \$250,000 you must submit a proof of good health form.

Your spouse or domestic partner can also obtain a policy under this portable term plan. Your children can be enrolled for a limited policy if either you or your spouse/domestic partner are enrolled. The levels and the premium rates are shown in Appendix C.

Refer to the Life Insurance brochure from your department's payroll specialist for more details on your life insurance benefits.

A Word About Beneficiaries

A beneficiary is the person who you name to receive your life insurance amount if you die. It is important that you designate your beneficiary via the ESS system. You may change by updating the information on OneSD via ESS. It is to your advantage to keep the beneficiary you name current. For example, if you get married, divorced, or the person you name as beneficiary dies, you may want/need to change your beneficiary.

What Do I Need To Submit To Enroll For The Portable Term Life Insurance?

An employee can only enroll for Portable Term Life insurance for him/herself or spouse/domestic partner or children by **completing and submitting** a life insurance application to Risk Management, Flexible Benefits Plan Section at MS # 51E.

Proof of Good Health is **required** if one of the following applies:

- Employee's coverage more than the simplified issue
 - \$250,000 – less than 60 years of age
 - \$50,000 – 60 years and above
- Open enrollment or at any time after hire or become eligible for benefits.
- Return to work – short term cancellation of policy
- Adding Spouse or Domestic partner (after hire date or become eligible for benefits).
- Adding Children (after hire date or become eligible for benefits).

MEDICAL BENEFITS

What Kind of Coverage is Available

The medical insurance you are eligible to select is shown on OneSD.

The chart on the next few pages describes the often used services of the medical plans offered through the City's Flexible Benefits Plan. The benefits described on the Medical Plans at a Glance are only an overview. To find out about specific coverages, please request a brochure from your department's payroll specialist.

Important Notice About Your Rights Under Your Group Medical Plan

When enrolling for medical coverage, you are agreeing to the Terms and Conditions of the medical plan provider. These terms are shown in each of the providers materials, and can also be viewed on the City intranet (City Net) or by clicking on the link on ESS.

The medical plans generally require or allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the specific medical plan insurance company in which you are enrolled. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the medical plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the specific medical plan insurance company in which you are enrolled.

Your medical plan provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema) as required by the Women's Health and Cancer Rights Act of 1998. Call your medical plan or Flexible Benefits at (619) 236-5924 for more information.

If you or a family member are eligible for Medicare, please refer to the notice on page 51 regarding prescription drug coverage.

When Your Coverage Begins

All of the medical plans are prepaid plans. Prepaid means that the payment for the current month pays for the following month.

Based on this, your coverage will begin on August 1st because the payment in July pays for August coverage.

If you are a new employee, you and your dependents are eligible for coverage on the first of the month following the date you were hired provided you make the pre-payment for your insurance. If you cannot afford to make a pre-payment, you may elect coverage to begin the month following prepayment being received. You and your dependents will be covered at the same time.

When Your Coverage Ends

Your Fiscal Year coverage will end on July 31st.

If you leave your job with the City before the fiscal year ends, your coverage will end on the last day of the month in which you terminate. At which time you may be eligible to continue your coverage under Federal law. See page 42 for details.

When Your Dependent's Coverage Ends

Your dependent's coverage will stop on the same day your coverage stops or on the date your dependent no longer qualifies as eligible, whichever is earlier.

Covering Your Dependents

You will enroll your eligible dependents via ESS. Be sure to enter all data (SSN, Date of birth, Gender), and if enrolling in a HMO medical plan that requires you to select a doctor or medical group, for each dependent you are enrolling.

The cost of your dependents will be paid with pre-tax dollars, unless the dependent is a domestic partner that is not an IRS qualified dependent. In this case, the cost for the domestic partner will be paid with after tax dollars.

Domestic partners can only be added to your medical insurance upon initial enrollment as a new hire or during open enrollment unless the domestic partner has lost their medical insurance or just became state registered. In either of these events, the domestic partner must be added within 30 days of the event.

It is important to know that if you choose to cover your dependents on your medical insurance and decide during the year to drop your dependent's coverage, FBP credits will be adjusted accordingly.

Dependent medical insurance premiums are not eligible to be reimbursed through the Dental/Medical/Vision Reimbursement option.

Coverage for Dependent Children

If you have dependent child(ren) ages 0 through 18, they may qualify for a no-cost medical, dental and vision insurance through the San Diego Kids Health Assurance Network (SDKHAN) or for a low-cost through Healthy Families. For further information, please call (800) 675-2229.

WAIVER OPTION

If you are covered by a comprehensive medical plan as of August 1st, you may opt out of medical insurance. Comprehensive medical plans must include physicians office visits, major services and hospitalization. Proof of coverage will be required at the time of enrollment.

If you have Medi-Cal insurance, you may not be eligible for this coverage once you are employed with the City because the City provides you medical insurance coverage. You will not be allowed to enroll for the Waiver Option.

If you have Veterans medical benefits, you will be required to show proof of comprehensive coverage. Some veterans medical benefits are covering treatment for injury only and no other medical benefits.

If you are a dependent on your parent's medical insurance, you may not be eligible to continue the medical insurance through your parent's employer because you are eligible for benefits through the City. If you are in this situation, please have your parent notify his/her employer to ask if you are still eligible to continue the medical insurance coverage before selecting the Waiver Option.

If you lose your other medical insurance coverage, you must enroll in a medical insurance from the City within 30 days from the loss of coverage.

Can I Waive My Insurance Coverage At Any Time After Open Enrollment?

If you are an MEA or Local 911 classified employee, you are *not* allowed to waive medical coverage except during open enrollment. However, you are allowed to cancel your dependents coverage at any time.

Local 127, POA, Local 145, DCAA, Unrepresented and Unclassified employees are allowed to waive medical coverage within **30 days** from gaining outside insurance coverage.

REIMBURSEMENT ACCOUNTS

Reimbursement Accounts for You

The City of San Diego provides certain benefit options as part of your Flexible Benefits Plan: Dental/Medical/Vision Reimbursement and Dependent Care Reimbursement. These plans are generally known as Flexible Spending Accounts (FSA).

These special accounts allow you to set aside tax-free dollars to pay for your health care and dependent care expenses.

Reimbursement Accounts Offer a Number of Important Advantages!

- They help you to budget your health care and dependent care expenses in advance of the upcoming year.

- You can fund these accounts through convenient payroll deductions.
- In most cases, these accounts save you from paying more taxes than through either itemized deductions or tax credits.

Savings on Taxes Mean More Money for You and Your Family

Because your contributions to both the Dental/Medical/Vision Reimbursement Account and the Dependent Care Reimbursement Account are taken out before your pay is taxed, you have more spendable income! Take a look at the chart below.

How to Save Taxes with the Dental/Medical/Vision and Dependent Care Reimbursement Accounts

	WITH THE REIMBURSEMENT ACCOUNTS	WITHOUT THE REIMBURSEMENT ACCOUNTS
BIWEEKLY BASIC EARNINGS:	\$1,500	\$1,500
MEDICAL CARE EXPENSES THROUGH THE DENTAL/MEDICAL/VISION REIMBURSEMENT ACCOUNT:	\$70	\$0
CHILD CARE EXPENSES THROUGH THE DEPENDENT CARE REIMBURSEMENT ACCOUNT:	\$150	\$0
REVISED BASIC EARNINGS:	\$1,280	\$1,500
ESTIMATED TAX (28%):	\$358	\$420
NET EARNINGS:	\$922	\$1,080
AFTER TAX MEDICAL CARE EXPENSES:	\$0	\$70
AFTER TAX CHILD CARE EXPENSES:	\$0	\$150
SPENDABLE INCOME:	\$922	\$860
INCREASE IN PAY DUE TO THE REIMBURSEMENT ACCOUNTS		\$62

By reducing your income, your SPSP contributions will be reduced as well. This is because Reimbursement Accounts reduce the wage base on which your contributions to this account is based. The following example illustrates the effects of Reimbursement Accounts on SPSP:

	WITH REIMBURSEMENT ACCOUNTS	WITHOUT REIMBURSEMENT ACCOUNTS	WITH REIMBURSEMENT ACCOUNTS	WITHOUT REIMBURSEMENT ACCOUNTS
BIWEEKLY EARNINGS:	\$1,500	\$1,500	\$2,000	\$2,000
DENTAL/MEDICAL/VISION REIMBURSEMENT ACCOUNT CONTRIBUTIONS:	\$70	\$0	\$70	\$0
DEPENDENT CARE REIMBURSEMENT ACCOUNT CONTRIBUTIONS:	\$150	\$0	\$150	\$0
REVISED BASIC EARNINGS:	\$1,280	\$1,500	\$1,780	\$2,000
SPSP:	\$77	\$91	\$108	\$121
CONTRIBUTION:	(6.05%)	(6.05%)	(6.05%)	(6.05%)
CITY MATCH:	\$77	\$91	\$108	\$121

The San Diego City Employees Retirement System (SDCERS), 401(k) and Deferred Compensation contributions will not be affected by your Reimbursement Account contributions.

How Do I Participate?

If you are eligible to participate in the City's Flexible Benefits Plan, you can enroll in one or both of the Reimbursement Accounts during the open enrollment period. Your accounts will be effective July 1, 2013. To participate, simply determine how much you would like to contribute to each account for the plan year.

Estimate Your Expenses Carefully

When you enroll in the Flexible Benefits Plan for the coming year, you will need to decide how much you want to set aside in one or both Reimbursement Accounts. Be sure you estimate your expenses carefully so you do not overfund your accounts. The IRS has some special rules that apply to your use of your Reimbursement Accounts because of the generous tax advantages they offer:

- **If you do not use all the money in your Dependent Care or Dental/Medical/Vision Reimbursement Accounts, you will lose it at the end of the Plan Year.** IRS regulations state that you must forfeit any money left in your Reimbursement Accounts when the Plan Year ends. These forfeitures cannot be deducted on your income tax return. Plan carefully before deciding how much to contribute to your Reimbursement Accounts. Set aside only the dollar amount you are certain you will use.
- **Dollars you put into your Dependent Care Reimbursement Account cannot be transferred to your Dental/Medical/Vision Reimbursement Account and vice-versa.** The accounts are separate, and the money you allocate for one kind of expense cannot be used for the other.

- **You may not change the amount you put into an account for the Plan Year.**
- **All claims for eligible expenses incurred during the plan year (July 1 – June 30) must be submitted no later than July 31st.**
- **Claims for expenses incurred while eligible for benefits must be received within thirty (30) days from date of termination or becoming ineligible, in order to be eligible for reimbursement.**

How Do I File A Claim For Reimbursement?

Before you file a claim for reimbursement, make sure you have gathered ALL eligible receipts/statements and/or Explanation of Benefits (EOB). You will need this when you enter your claim through Employee Self-Service (ESS).

Dental/Medical/Vision receipts **must** contain the following **required** information:

- Patient's Full Name
- Physician or Store (Pharmacy or Eyewear)
 - Name
 - Address
 - Phone No.
- Date of Service
- Description of Service or Prescription Number
- Cost of Drugs or Service

Dependent Child Care receipts **must** contain the following **required** information:

- Child's Name
- Day Care Provider's
 - Name
 - Address
 - Phone No.
 - Tax I.D. number
- Date of Service
- Description of Service

NOTE: If your receipt is missing any of the required information, your claim will be rejected until the necessary information is submitted.

Log in to Employee Self-Service (ESS) to enter **each** reimbursement claim. Do **NOT** lump your receipts all together. Each claim will be matched with each receipt. If your claim and receipts do **not** match, your claim will be rejected.

Scan your receipts and email them to the **Reimbursement Administrator** from City's Outlook address book.

Once your receipt is received, it will be matched with the claim you entered in ESS and processed for approval by the Flexible Benefits staff.

How Soon Will My Claim Be Processed?

Generally your claim will be processed within 4 to 6 weeks of scanning the required documentation depending on the volume of claims received during the period you submit your claim. The claim and receipt will be reviewed and approved or rejected by Flexible Benefits staff.

A notification will be emailed or mailed (interoffice mail) to you if your claim and receipt have been rejected.

The approved claim amount will be included on your paycheck. Please allow at least 2 weeks from the date you email your scanned documents for the claim to be processed and another 2 weeks for the claim amount to be included on your paycheck. Depending on the payroll cycle process your claim may not be paid until the next payroll cycle which is the reason it could be up to 6 weeks before you receive the payment.

If you do not receive payment **after 8 weeks** from the date you first emailed the scanned documents email the RMGT Reimbursement Administrator.

DENTAL/MEDICAL/VISION REIMBURSEMENT

Dental/Medical/Vision (DMV) Reimbursement Account

Your elections under the Flexible Benefits Plan will cover most routine medical, dental, and vision expenses during the year. But you may have additional expenses throughout the year that are not covered by the plans you elected, such as deductibles, copayments, and coinsurance amounts that are part of your out-of-pocket expenses for health care treatment. If you have not set aside the money for these expenses in the DMV Reimbursement Account, you will be paying these expenses with after-tax dollars.

The DMV Reimbursement Account is an excellent way to pay for some of these expenses. When you establish this account, you set aside tax-free dollars to cover eligible health care expenses you expect to incur throughout the year.

There Are a Lot of Eligible Expenses!

You have a wide variety of expenses which could be paid with the money in your DMV Reimbursement Account. Some of these include:

- Medical, dental, and vision care annual deductibles, copayments, and coinsurance amounts
- Your share of costs for routine check-ups, well baby care, immunizations, and other preventive benefits.
- Prescribed supplies or medicines
- Prescription sunglasses
- LASIK or similar vision correction surgery

Certain expenses **are not eligible** for reimbursement through a DMV Reimbursement Account. These include such expenses as:

- Over-the-counter medications and supplies to treat illness or injury
- Your premium payments for medical, dental, and vision coverage plans for yourself or your dependents
- Funeral expenses
- Nonprescription vitamins for overall general health
- Diaper service
- Dependent care expenses for a child or a disabled member of your household
- Cosmetic treatment for cosmetic reasons

The General Rule for Determining an Eligible Expense

- The IRS must consider the medical expense to be a tax deductible item and
- The expense must not be covered under any employer-sponsored or personal insurance plan and
- You may not deduct the expense on your income tax return

Remember, if you do decide to itemize deductions on your federal tax return, your medical expenses must exceed 7½% of your annual gross income to qualify for a deduction. Because of this rule, the DMV Reimbursement Account may be a better way to reduce your tax bill. With the DMV Reimbursement Account, your contributions are not taxed at all.

Whose Expenses Can Be Reimbursed?

You may submit claims for yourself and your eligible dependents. Eligible dependents include:

- Your spouse and dependent children
- Any regular member of your household so long as you provide over half of the individual's financial support and claim the individual as a dependent on your tax return. A copy of your tax return will be required for the year you claimed the individual as a dependent.

Dollars and Sense

The maximum you can set aside to a DMV Reimbursement Account is \$2,500 a year (and indexed annually) through tax-free payroll deductions. As you and your eligible dependents incur expenses throughout the plan year, you can then reimburse yourself 100% up to the amount you set aside in your account for the upcoming year.

All health care expenses you incur during the plan year (July 1 to June 30) must be submitted for reimbursement by July 31st of the following plan year. You are eligible for your entire annual DMV Reimbursement Account amount at any time during the plan year.

What If I Miss A Contribution Deducted on My Paycheck Due To Leave Of Absence Without Pay?

The annual amount you elected to be deducted from your paycheck will be deducted over 26 pay periods or the remaining pay periods for the fiscal year July 1 – June 30. If you miss a deduction for FSA DMV, your biweekly deduction will be adjusted automatically to deduct for the remaining pay periods in the fiscal year.

As an example: If you allocated \$260 for the plan year July 1 – June 30, your biweekly payroll deduction will be \$10 a pay period for 26 pay periods. If you miss a deduction due to leave of absence without pay, the system will calculate the amount that needs to be collected that was missed and divide that over the remaining pay periods in the fiscal year. In this example let's say that you had contributed for 10 pay periods for a total of \$100 leaving a balance of \$160 to be contributed for the remainder of the year. Your new payroll deduction amount will be \$11.43 (\$160 divided by the remaining pay periods).

The Following Conditions Must Be Met

You must submit claims to be reimbursed for expenses incurred for you and your dependents.

You must be in a pay status, including Industrial Leave and Long-Term Disability. If you are on Leave Without Pay, amounts will not accrue to this option. Any expenses incurred during this unbenefitted status will not be eligible for reimbursement unless you continue to pay the necessary premiums. Your annual allotment will be reduced by the amount of missed contributions during this unbenefitted status.

You must use your money by June 30th. If you do not, all remaining amounts will be forfeited. This benefit is not carried forward to the next benefit year.

What Kind of Doctors?

Services must be received from a physician who is licensed to practice medicine and surgery as a doctor of medicine, M.D. or as a doctor of osteopathy, D.O. While acting within the scope of his/her license and to the extent that benefits are provided, physician shall include a person licensed to practice as a dentist (including orthodontist, dental assistant, or hygienist acting under the direction of a licensed dentist), podiatrist, chiropractor, clinical psychologist, optometrist, or ophthalmologist.

What Kind of Expenses?

Reimbursements will be made for services, medications, and supplies that have been prescribed by a licensed physician or those licensed specialists shown under the "What Kind of Doctors" section above. The expenses must also meet Internal Revenue Service guidelines.

Internal Revenue Code §213 defines "medical care" as amounts paid for the "diagnosis, care, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body." Based on IRS rules, the type of expenses which may be reimbursed under the City's reimbursement plan are limited. For example, the following expenses are not reimbursable:

- premiums for other health coverage, including premiums paid for dependent health coverage through the City's plans or for health coverage under a plan maintained by the employer of your dependent (including your spouse)
- weight loss programs unless medically necessary
- food or food supplements in connection with medically necessary weight loss programs
- personal items (mattress, television, computer, spa)
- eyeglass frames alone without prescription lenses
- transportation (mileage and parking fees)
- lodging

A general list of allowable expenses is provided in Appendix F. The general list is in no way an exhaustive list of what is reimbursable under DMV Reimbursement. It is also important to note that not all expenses allowed to be claimed on your taxes under IRC §213 are eligible to be reimbursed under the City's DMV Reimbursement Plan.

When Are Expenses Eligible?

Expenses must be incurred (received) during the plan year and while you are eligible for the benefit.

Expenses are treated as having been incurred when the participant is provided with the medical care that gives rise to the medical expenses, and not when the participant is formally billed or charged for, or pays for the medical care.

In the case of supplies, such as eyeglasses, prescriptions, etc., expenses are deemed incurred at the time they are ordered, not when paid for or received.

Crowns, bridges and root canal are deemed incurred at the time they were initially started, not when they were permanently set.

Orthodontia

In the case of non-cosmetic orthodontic treatment (braces), it is recommended that you speak with a Flexible Benefits representative before contracting for orthodontia or designating money for reimbursement through the DMV Reimbursement account.

Due to the unique nature of orthodontia expenses, the following special documentation requirements have been established:

- the first orthodontia claim submitted must include a copy of the written agreement between you and the orthodontist, indicating the total estimated charges and the period of treatment.
- all claims submitted must include statements or receipts from the orthodontist as evidence of services rendered.
- if you have insurance, you must submit the claim to the insurance company and then submit the Explanation of Benefits worksheet with your first DMV claim.

If you pay for orthodontic treatment over time, the plan will allow for reimbursement as follows: A maximum of 33 1/3% of the total cost can be reimbursed at the initiation of the services, if your first payment was less than 1/3 of the total cost, the initial reimbursement will be limited to that amount. The balance will be allowed based on the orthodontist's regular billing dates (monthly, quarterly, etc.) over the course of the treatment period.

Some orthodontists offer a discount if payment in full is made at the beginning of treatment. If you take advantage of this option, it is important to note that the DMV Reimbursement Plan can only reimburse for services actually rendered during the effective plan year (July 1 – June 30). Therefore, a maximum of 33 1/3% of the total cost can be reimbursed at the initiation of the services. The balance will be prorated over the number of months of treatment stated under your contract. The monthly fee will be reimbursed thereafter as long as treatment was rendered that month. The following example is provided for further explanation: In October,

you contract with your orthodontist to have braces put on your child's teeth. During the first visit (November) the child is x-rayed and fitted for braces. During the second visit (December), the braces are applied to the teeth. During the next 15 months, monthly visits are made to adjust the braces. Eventually (18 months after the first visit, if all goes as planned) the braces will be removed, and a retainer will be fitted for use thereafter. For all these services, you pay \$3,000 on the date of the first visit.

In this example, because all the services will not be received in the plan year, you are not eligible to receive reimbursement for the full \$3,000 in the plan year. You will need to have the orthodontist apportion (separate) the \$3,000 to the office visits your child makes over the contract's 18-month period. If the orthodontist estimates that one-third of the total time that he or she will spend with the child (and one-third of the expense for supplies) occurred during the first two visits, and that the remaining time and expenses will be spread evenly over the remaining months, then \$ 1,000 is eligible to be received after the December visit and the remaining \$2,000 will be eligible to be paid each month thereafter in equal amounts ($\$2,000/16 = \125). In this case, the amount eligible for reimbursement is \$1,750 ($\$1,000 + \125×6 months – January through June).

The orthodontist's letter certifying that the orthodontic treatment is not cosmetic and apportioning the costs must be attached to the first reimbursement claim form submitted.

Information Before You File a Claim

- Services, prescribed medicines, and supplies must be received during the benefit year (July 1st through June 30th or up to date of termination, whichever comes first).
- All claims for reimbursement for the Benefit Year must be entered in ESS no later than July 31st or 30 days after termination or becoming ineligible for this plan, whichever is earlier.

DEPENDENT/CHILDCARE REIMBURSEMENT

A Dependent Care Reimbursement Account works much like a Dental/Medical/Vision Reimbursement Account. If you have eligible dependent care expenses, you can set aside tax-free dollars to cover these expenses throughout the year.

The expenses incurred by your eligible dependents for “day” care may be reimbursed by the City. Dependent care expenses are defined as:

- amounts paid for the care of a dependent in your home or at a dependent care facility which meets all the applicable requirements of state or local law, or is exempt from those requirements.

Who is Eligible for Coverage by a Dependent Care Reimbursement Account?

- Your child under the age of 13 whom you claim on your federal tax return
- Other dependents, such as your spouse, an elderly parent, or an older child who cannot care for themselves because of a physical or mental disability, and whom you claim as a dependent on your tax return.

A dependent can be any person who regularly lives with you at least 8 hours a day and that you provide at least half of their financial support. Dependents do not have to be members of your family.

Who Can Set Up an Account?

If you are a single working parent and pay for dependent care for eligible dependents, you can set up a Dependent Care Reimbursement Account. If you are married, your spouse must also work or go to school full-time to qualify you for the Dependent Care Reimbursement Account.

What Are Eligible Dependent Care Expenses?

Like the Dental/Medical/Vision Reimbursement Account, you have a wide variety of expenses which could be paid with the money in your Dependent Care Reimbursement Account. Some of these include:

- At-home day-care provider(s), unless the care is provided by your child under 19 years old, or by someone else you claim as a dependent
- Day-care centers
- Summer day camps
- Nursery schools
- Preschool
- Child care provided before or after school hours

What Are NOT Eligible Dependent Care Expenses?

Certain expenses are not eligible for reimbursement through a Dependent Care Reimbursement Account. These include such expenses as:

- Overnight camps
- Babysitting so you can attend a social event
- Food and education expenses for a child in kindergarten or higher
- Payment for dependent medical care expenses
- Cost of care provided by another dependent
- Tuition or school registration
- amounts paid to your child younger than 19 who cares for your dependent
- amounts paid to your dependent if you are entitled to claim that dependent as an exemption for Federal income tax purposes
- amounts paid for or reimbursed under any Federal, State or local child care assistance program
- amounts paid for or reimbursed under your spouse’s employer- sponsored program or under an educational institution program, or any other source other than this plan.

How Much You Can Contribute?

If you are single or married (filing a joint return), you can set aside up to \$5,000 for your household – tax-free – per plan year in your Dependent Care Reimbursement Account. If you are married and you and your spouse file separate returns, you can set aside up to \$2,500 per year tax free.

What If I Missed A Contribution Deducted on My Paycheck Due To Leave Of Absence Without Pay?

The Dependent Care reimbursement is based on your biweekly contribution paid to date. If you allocated \$2600 for the plan year July 1 to June 30, your payroll deduction will be \$100 a pay period for 26 pay periods. If you miss a deduction for one or several pay periods due to leave of absence without pay, you cannot be reimbursed if you don't have any money left in your dependent care reimbursement account. Your biweekly deduction will not increase to compensate for the missed deduction during the time you were on a leave of absence without pay.

When You Can Be Reimbursed

Your expenses must be incurred on or after your and your dependent's effective date of coverage. The date you receive services is the date they will be deemed incurred.

The City will reimburse your dependent care expenses when you are in a pay status, including Industrial Leave and Long-Term Disability. If you are on Leave Without Pay or other unbenefitted status, amounts will not accrue to this option. Any expenses incurred during this unbenefitted status will not be eligible for reimbursement.

Dependent Care Reimbursement Account vs. Tax Credit

Before enrolling in a Dependent Care Reimbursement Account, you should evaluate whether a tax credit taken on your federal income tax return will save you more money than the Dependent Care Reimbursement Account.

You Should Consider That:

- Your eligible dependent care expenses are the same expenses that would qualify for credit on your federal income tax return.
- You may not take a tax credit for expenses funded through your reimbursement account. In fact, each dollar you place in the dependent care account reduces the amount you can claim for a tax credit by \$1.

To help you determine if the tax credit offers you greater tax advantages than a reimbursement account, you may want to consult a tax advisor.

The Effect on Your Taxes

- Dependent care expenses must meet all Internal Revenue Service requirements.
- You will receive a written statement showing the amounts paid by the City for the previous calendar year. The City will provide this statement on or before January 31st of each year. The City will report the amount you received during the year on your W-2.
- § 21 of the Internal Revenue Code allows an income tax credit for dependent care expenses of up to \$3,000 for one dependent and \$6,000 for two dependents. This credit will be reduced, dollar for dollar, by the amounts you receive under the City's plan. For example:

You have one child and \$4,000 in dependent care expenses. You receive \$1,000 from the Dependent Care Reimbursement option. You will only be able to use \$2,000 toward the dependent care tax credit ($\$3,000 - \$1,000 = \$2,000$)

Because of this law, you will have to decide if the Dependent Care Reimbursement option or the tax credit, or a combination of both, will be the best choice for you.

ALLOWABLE DENTAL, MEDICAL OR VISION EXPENSES

The Internal Revenue Service has issued a complete list of eligible expenses for Section 125 reimbursement accounts. Below is a list of the most common items for which an employee can receive medical reimbursement. Of course, for expenses also covered under group health plans, employees can only be reimbursed for the amount they incurred "out of pocket" due to deductibles, co-payments or charges over any policy limitations.

Fees and Services

Abortions, legal
Ambulance Hire
Anesthesiologist
Care for the Mentally Handicapped
Chiropractic Care
Devices (medically necessary)
Christian Science Practitioners Fees
Dermatologist Fees*
Education for the Blind
Fees for Healing Services
Hospital Fees—
Hypnosis for Treatment of an Illness
Laboratory Fees
Medical Information Plan
Nursing Care
Obstetrical Expenses
Physical/Mental Illness Confinement
Physician Fees
Practical Nurse Fees
Psychiatric Care
Psychologist Fees
Schools for the Mentally Handicapped
Sterilization Fees
Surgical and Diagnostic Fees

Medical Equipment

Artificial Limbs
Car Controls for the Handicapped
Communication Equipment for the Deaf
Crutches
Hearing Aids/Batteries
Orthopedic Shoes
Oxygen Equipment
Wheelchairs
Wigs (for hair loss due to medical reasons)

Dental and Orthodontic Care

Artificial Teeth
Braces, Orthodontic*
Dental Fees
Dentures

Physical Examinations

Routine and Preventive Physicals
School and Work Physicals

Vision Care

Braille Books and Magazines (cost in excess of regular printed materials)
Optometrist's Fees
Ophthalmologist's Fees
Seeing-eye Dog and Its Care

Therapy/Treatment

Acupuncture
Special Diets*
Speech Therapy
Treatment for Alcoholism or Drug Addiction
Vaccinations
X-Ray Treatments

*Prescription Drugs***

Birth Control Pills
Laetrile by prescription
Prescription Drugs or Insulin
Vitamins by prescription (dispensed by pharmacist)

*Over the counter drugs****

* Must be medically necessary. Doctor's Medically Necessary Statement form required.

** Drugs purchased outside the U.S. are not reimbursable.

*** Written Prescription from a licensed physician is required. Receipts must have patient's name.

CONTINUATION OF COVERAGE

Continuation of Coverage (COBRA)

How to Continue Your Medical Insurance Participation

It is important that all covered individuals (employee, spouse, and dependent children) take the time to read this notice carefully and be familiar with its contents. If there is a covered dependent not living at your current address, please provide Flexible Benefits Plan Section with the appropriate address so that a notice can be sent to them as well.

Under a federal law commonly known as COBRA, the City of San Diego is required to offer you, your spouse and dependent children the opportunity to temporarily continue medical coverage at group rates where coverage under the plan would otherwise be

reduced or terminated because of certain life events (known as a “qualifying events”, which are described in more detail later in this notice). Individuals entitled to COBRA continuation coverage (known as “qualified beneficiaries”) are you, your spouse and dependent children who are covered under the plan at the time of a qualifying event. In addition, a child who is born to you or adopted or placed for adoption with you during the COBRA coverage period is also a qualified beneficiary.

This notice is simply intended to inform you (and your covered dependents, if any), in a summary fashion of your potential future options and obligations under COBRA. Should an actual qualifying event occur in the future, Flexible Benefits Plan Section will send you the appropriate notification. **Please take special note, however, of your notification obligations which are highlighted in this notice.**

The tables below and on the next page provides a summary of the COBRA provisions outlined in this section.

Qualifying Events That Result in Loss of Coverage	Maximum Continuation Period		
	Employee	Spouse	Child
Employee’s work hours are reduced and results in loss of coverage	18 months	18 months	18 months
Employee terminates employment for any reason (other than gross misconduct)	18 months	18 months	18 months
Employee becomes entitled to Medicare as a retiree	N/A	36 months	36 months
Employee or dependent is disabled (as determined by the Social Security Administration) at the time of the qualifying event or becomes disabled within the first 60 days of COBRA continuation that begins as a result of termination or reduction in work hours	29 months	29 months	29 months
Employee dies	N/A	36 months	36 months
Employee and spouse legally separate or divorce	N/A	36 months	36 months
Employee becomes entitled to Medicare within 18 months prior to termination of employment or reduction in work hours	N/A	36 months*	36 months*
Child no longer qualifies as a dependent	N/A	N/A	36 months

* 36-month period is counted from the date you become entitled to Medicare.

Qualifying Events That Result in Loss of Coverage	Maximum Continuation Period		
	Employee	Spouse	Child
For medical coverage only, after initial 18-month federal COBRA coverage (caused by termination of employment or reduction in work hours) has been exhausted, an employee and covered dependents are entitled to Cal-COBRA extended coverage.	18 months	18 months	18 months

Qualifying Events

If your employment terminates for any reason other than your gross misconduct or if your hours worked are reduced so that your plan coverage terminates, you, your covered spouse and dependent children may continue medical coverage under the plan for up to 18 months.

If you should die, become legally separated or divorced, or become entitled to Medicare as a retiree, your covered dependents whose medical coverage under the plan would be reduced or terminated may continue medical coverage under the plan for up to 36 months. Also, your covered children may continue medical coverage for up to 36 months after they no longer qualify as covered dependents under the terms of the plan.

Certain events may extend an 18-month COBRA continuation period applicable to your termination of employment or reduction in hours worked:

- If your dependents experience a second qualifying event within the original 18-month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event).
- If you (the employee) became entitled to Medicare while employed (even if it was not a qualifying event for your covered dependents because their coverage was not lost or reduced) and then a second qualifying event (such as your termination of employment or reduction in hours of work) happens within 18 months, your dependents may elect COBRA continuation for up to 36 months from the date you became entitled to Medicare.

- If you or your dependent is disabled (as determined by the Social Security Administration) on the date of a termination of employment or reduction in work hours or at any time during the first 60 days of COBRA continuation coverage due to such event, each qualified beneficiary (whether or not disabled) may extend COBRA continuation coverage for up to an additional 11 months (for a total of up to 29 months). To qualify for this disability extension, Risk Management – Benefits Division must be notified of the person’s disability status both within 60 days after the Social Security disability determination is issued and before the end of the original 18-month COBRA continuation period. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify Risk Management – Benefits Division within 30 days after this determination.
- Upon completion of the original 18-month COBRA continuation period you and your covered dependents may extend the period for an additional 18-month period under California COBRA. Your insurer will provide you notice of your extension rights prior to your original COBRA ending.

IMPORTANT NOTE: If a second qualifying event occurs at any time during this 29-month disability continuation period, then each qualified beneficiary who is a spouse or dependent child (whether or not disabled) may further extend COBRA coverage for seven more months, for a total of up to 36 months from the termination of employment or reduction in hours of employment.

Continuation of Coverage (COBRA)

How to Continue Your Medical Insurance Participation

It is important that all covered individuals (employee, spouse, and dependent children) take the time to read this notice carefully and be familiar with its contents. If there is a covered dependent not living at your current address, please provide Flexible Benefits Plan Section with the appropriate address so that a notice can be sent to them as well.

Under a federal law commonly known as COBRA, the City of San Diego is required to offer you, your spouse and dependent children the opportunity to temporarily continue medical coverage at group rates where coverage under the plan would otherwise be reduced or terminated because of certain life events (known as a “qualifying events”, which are described in more detail later in this notice). Individuals entitled to COBRA continuation coverage (known as “qualified beneficiaries”) are you, your spouse and dependent children who are covered under the plan at the time of a qualifying event. In addition, a child who is born to you or adopted or placed for adoption with you during the COBRA coverage period is also a qualified beneficiary.

This notice is simply intended to inform you (and your covered dependents, if any), in a summary fashion of your potential future options and obligations under COBRA. Should an actual qualifying event occur in the future, Flexible Benefits Plan Section will send you the appropriate notification. **Please take special note, however, of your notification obligations which are highlighted in this notice.**

Qualifying Events

If your employment terminates for any reason other than your gross misconduct or if your hours worked are reduced so that your plan coverage terminates, you, your covered spouse and dependent children may continue medical coverage under the plan for up to 18 months.

If you should die, become legally separated or divorced, or become entitled to Medicare as a retiree, your covered dependents whose medical coverage under the plan would be reduced or terminated may continue medical coverage under the plan for up to 36 months. Also, your covered children may continue medical coverage for up to 36 months after they no longer qualify as covered dependents under the terms of the plan.

Certain events may extend an 18-month COBRA continuation period applicable to your termination of employment or reduction in hours worked:

- If your dependents experience a second qualifying event within the original 18-month period, they (but not you) may extend the COBRA continuation period for up to an additional 18 months (for a total of up to 36 months from the original qualifying event).
- If you (the employee) became entitled to Medicare while employed (even if it was not a qualifying event for your covered dependents because their coverage was not lost or reduced) and then a second qualifying event (such as your termination of employment or reduction in hours of work) happens within 18 months, your dependents may elect COBRA continuation for up to 36 months from the date you became entitled to Medicare.
- If you or your dependent is disabled (as determined by the Social Security Administration) on the date of a termination of employment or reduction in work hours or at any time during the first 60 days of COBRA continuation coverage due to such event, each qualified beneficiary (whether or not disabled) may extend COBRA continuation coverage for up to an additional 11 months (for a total of up to 29 months). To qualify for this disability extension, Risk Management – Benefits Division must be notified of the person’s disability status both within 60 days after the Social Security disability determination is issued and before the end of the original 18-month COBRA continuation period. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify Risk Management – Benefits Division within 30 days after this determination.
- Upon completion of the original 18-month COBRA continuation period you and your covered dependents may extend the period for an additional 18-month period under California COBRA. Your insurer will provide you notice of your extension rights prior to your original COBRA ending.

IMPORTANT NOTE: If a second qualifying event occurs at any time during this 29-month disability continuation period, then each qualified beneficiary who is a spouse or dependent child (whether or not disabled) may further extend COBRA coverage for seven more months, for a total of up to 36 months from the termination of employment or reduction in hours of employment.

Giving Notice That a COBRA Event Has Occurred

To qualify for COBRA continuation upon legal separation, divorce or loss of your child's dependent status under the plan, you or one of your dependents **MUST** notify Flexible Benefits Plan Section of the legal separation, divorce or loss of dependent status within 60 days of the later of the date of the event or the date the individual would lose coverage under the plan. Your covered dependents then will be provided with instructions for continuing your medical coverage. Individuals already on COBRA continuation must notify Flexible Benefits Plan Section within these deadlines if a legal separation, divorce or loss of a child's dependent status occurs that would extend the period of COBRA coverage for your spouse or dependent child(ren). Carefully read the dependent eligibility rules contained in the Flexible Benefits Summary Highlights. To delete an eligible dependent, complete the appropriate Family Account change form available on the intranet or from your payroll specialist and submit it to Flexible Benefits Plan Section (their address is located at the end of this notice). If this notification is not completed in a timely manner, then rights to COBRA continuation coverage may be forfeited.

For other qualifying events (i.e., if your employment ends, your hours are reduced, you become entitled to Medicare, or you die), the City of San Diego has the responsibility to notify Flexible Benefits Plan Section of the qualifying event, and Flexible Benefits staff will then provide you and/or your covered dependents with instructions for continuing medical coverage.

Electing and Paying for COBRA Continuation Coverage

You and/or your covered dependents must choose to continue coverage within 60 days after the later of the following dates:

- The date you and/or your covered dependents would lose coverage as a result of the qualifying event
- The date Risk Management – Benefits Division notifies you and/or your covered dependents of your right to choose to continue coverage as a result of the qualifying event.

Premium Due Date: If you elect COBRA continuation coverage, you must pay the initial premium (including all premiums due but not paid) within 45 days after your election. Thereafter, COBRA premiums must be paid monthly and within 30 days of each due date. If you elect COBRA continuation but then fail to pay the premium due within the initial 45-day grace period, or you fail to pay any subsequent premium within 30 days after the date it is due, your coverage will be terminated retroactively to the last day for which timely payment was made.

Cost

Continuing Active or Retiree Coverage: The cost of COBRA coverage is 102% of the full cost of plan coverage.

Additional Cost Requirements for Continuation of Active Coverage Only: The cost of coverage for the 19th through 29th months of coverage under the disability extension is 1) 150% of the full cost of coverage for all family members participating in the same coverage option as the disabled individual, and 2) 102% for any family members participating in a different coverage option than the disabled individual, except as provided below.

If a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months even if the individual is disabled. However, if a second qualifying event occurs during the otherwise applicable disability extension period (that is, during the 19th through 29th month), then the rate for the 19th through 36th months of the COBRA continuation period is 1) the 150% rate for all family members participating in the same coverage option as the disabled individual, and 2) the 102% rate for any family members in a different coverage option than the disabled individual.

The cost for Cal-COBRA extended coverage beyond the original 18-month COBRA continuation period without a secondary qualifying event is generally 110% of the full cost of plan coverage.

Coverage During the Continuation Period

If coverage under the plan is changed for active employees, the same changes will be provided to individuals on COBRA continuation. Qualified beneficiaries also may change their coverage elections during the annual enrollment periods, if a change in status occurs, or at other times under the plan to the same extent that similarly situated non-COBRA employees or retirees may do so.

When COBRA Continuation Coverage Ends

COBRA continuation of medical coverage for any person will end when the first of the following occurs:

- The applicable continuation period ends.
- The initial premium for continued coverage is not paid within 45 days after the date COBRA is elected, or any subsequent premium is not paid within 30 days after it is due.
- After the date COBRA is elected, the qualified beneficiary first becomes covered (as an employee or otherwise) under another group medical plan not offered by the City of San Diego, and the other plan does not contain an exclusion or limitation affecting the person's preexisting condition, or the other plan's preexisting condition limit or exclusion does not apply or is satisfied because of the HIPAA rules.
- After the date COBRA is elected, the qualified beneficiary first becomes entitled to Medicare. (This does not apply to other qualified beneficiaries who are not entitled to Medicare.)
- In the case of the extended coverage period due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months.
- For newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation period, the date your COBRA continuation period ends unless a second qualifying event has occurred.
- The City of San Diego terminates all group medical coverage for all employees and retirees.
- A qualified beneficiary notifies Risk Management–Benefits Division that they wish to cancel COBRA coverage.

When your COBRA coverage terminates, you may be able to convert your coverage to individual, nonplan coverage under the plan's conversion rights feature. Contact Risk Management – Benefits Division for further details.

Notification of Address Change

To ensure that all covered individuals receive information properly and efficiently, it is important that you notify your payroll specialist of any address change as soon as possible. Failure on your part to do so may result in delayed notifications or a loss of COBRA coverage options.

Any Questions

If a covered individual does not understand any part of this summary notice or has questions regarding the information or your obligations, please contact the Flexible Benefits Plan Section, 1200 Third Avenue, Suite 1000, San Diego, CA 92101, (619) 236-5924.

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes conditions on how a group health plan may use and disclose your individual health information, referred to here as “protected health information.” It also gives you certain rights with respect to that information.

This notice describes the privacy practices of the City of San Diego Employees’ Flexible Benefits Plan.

The plans covered by this notice may share health information with each other to carry out Treatment, Payment, or Health Care Operations, as described below.

If you are covered by an insured medical option under the Plan (e.g., Kaiser, HealthNet, Sharp) you will also receive a separate notice from your medical plan insurer or HMO.

It is important to note that HIPAA’s privacy rules only apply to health plans. Different policies may apply to other City of San Diego-sponsored programs, such as life insurance or disability.

The Plan’s Responsibilities

The Plan is required by law to maintain the privacy of your protected health information and to inform you about:

- The Plan’s practices regarding the use and disclosure of your protected health information;
- Your rights with respect to your protected health information;
- The Plan’s duties with respect to your protected health information;
- Your right to file a complaint about the use of your protected health information;
- A breach in your PHI; and
- Whom you may contact for additional information about the Plan’s privacy practices.

The Plan will follow the terms of this notice, as it may be updated from time to time. The Plan reserves the right to change the terms of its privacy policies at any time and to make new provisions effective for all health information that the Plan maintains.

How the Plan May Use or Disclose Your Health Information

The privacy rules generally allow the use and disclosure of your health information without your written authorization for purposes of Treatment, Payment and Health Care Operations. Here are some examples of what this encompasses:

- **Treatment** includes providing, coordinating, or managing health care by a health care provider or doctor. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share health information about you with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.
- **Health Care Operations** include activities by the Plan such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and the claims and appeal process. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. For example, the Plan may use information about your claims to review the effectiveness of wellness programs.

The Plan will only disclose the minimum information necessary with respect to the amount of health information used or disclosed for these purposes. In other words, only information relating to the task being performed will be used or disclosed. Information not required for the task will not be used or disclosed.

The Plan may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

How the Plan May Share Your Health Information with the City of San Diego

The Plan may disclose your health information without your written authorization to certain employees of the City of San Diego who have been identified as performing plan administration functions. These employees will only use or disclose that information as necessary to perform plan administration functions

or as otherwise required by HIPAA, unless you have authorized further disclosures.

In addition, the HIPAA rules allow information to be shared between the Plan and the City of San Diego, as follows:

- The Plan may disclose “summary health information” to the City of San Diego if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants’ claims information, but from which names and other identifying information have been removed.

- The Plan may disclose to the City of San Diego information as to whether an individual is participating in the Plan, or has enrolled or disenrolled in a health benefit option offered by the Plan.

In addition, you should know that the City of San Diego cannot and will not use health information obtained from the health plans for any employment-related actions.

However, health information collected by the City of San Diego from sources other than the Plan, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers’ compensation is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

The Plan may not use genetic information for underwriting purposes.

Other Allowable Uses or Disclosures of Your Health Information. Generally, the Plan may disclose your protected health information to a friend or family member that you have identified as being involved in your health care or payment for that care. In the case of an emergency, information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). In addition, your health information may be disclosed without authorization to your legal representative.

As required by law	Disclosures to federal, state or local agencies in accordance with applicable law.
Workers’ compensation	Disclosures to workers’ compensation or similar programs in accordance with federal, state or local laws.
To prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety; includes disclosures to assist law enforcement officials in identifying or apprehending an individual in certain circumstances.
Public health activities	Disclosures for public health reasons, including: (1) to a public health authority for the prevention or control of disease, injury or disability; (2) a proper government or health authority to report child abuse or neglect; (3) to report reactions to medications or problems with products regulated by the Food and Drug Administration; (4) to notify individuals of recalls of medication or products they may be using; (5) to notify a person who may have been exposed to a communicable disease or who may be at risk for contracting or spreading a disease or condition.
Victims of abuse, neglect, or domestic violence	Disclosures to report a suspected case of abuse, neglect, or domestic violence, as permitted or required by applicable law.
Judicial and administrative proceedings	Disclosures in response to an order of a court or administrative tribunal or in response to a subpoena, discovery request, or other lawful process.
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process for law enforcement purposes.
Death	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties.
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death.
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project.
Health oversight activities	Disclosures to comply with health care system oversight activities, such as audits, inspections, or investigations and activities related to health care provision or public benefits or services.
Specialized government functions	Disclosures to facilitate specified government functions related to the military and veterans, national security or intelligence activities; disclosures to correctional facilities about inmates.
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan’s compliance with the HIPAA privacy rule.
Fundraising	You may be contacted for purposes of fundraising, however you may opt-out of current and future fundraising activities.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Except as described in this notice, other uses and disclosures of PHI, such as marketing purposes, use of psychotherapy notes, and disclosures that constitute the sale of PHI will be made only with your written authorization. However, certain communications are permitted, such as general health promotion and government sponsored programs.

You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made.

Your Individual Rights

You have the following rights in connection with your health information that the Plan maintains. These rights are subject to certain limitations, described below. Remember, the City of San Diego does not generally receive or maintain individually identifiable health information from the Plan. In most cases, you should direct your requests to your medical or dental plan service representative.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse. You have the right to request a restriction or limitation on the Plan's use or disclosure of your health information. For example, you have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care.

You have the right to request that PHI concerning a health care item or service which has been paid in full not be disclosed to a health plan for payment, or health care operations. However, you cannot restrict disclosure of information necessary to make the payment.

Because the Plan only uses your health information to administer the Plan, and to comply with the law, it may not be possible to agree to your request. The law does not require the Plan to agree to your request for restriction. However, if the Plan agrees, the Plan will comply with the restriction unless the information is needed to provide emergency treatment to you.

Right to receive confidential communications of your health information. You have the right to request that the Plan communicate with you about your health information at an alternative address or by alternative means if you think that communication through normal processes could endanger you in some way. For example, you may request that the Plan only contact you at work and not at home.

Right to inspect and copy your health information. You have the right to inspect or obtain a copy of your health information contained in records that the Plan maintains for enrollment, payment, claims determination, or case or medical management activities, or that the Plan uses to make enrollment, coverage or payment decisions. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage.

Right to amend your health information that is inaccurate or incomplete. With certain exceptions, you have a right to request that the Plan amend your health information if you believe that the information the Plan has about you is incomplete or incorrect. You must include a statement to support the requested amendment. The Plan will notify you of its decision to grant or deny your request.

Right to receive an accounting of disclosures. You have the right to a list of certain disclosures of your health information. The accounting will not include: (1) disclosures made for purposes of Treatment, Payment or Health Care Operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosure for national security purpose; and (6) disclosures incident to other permissible disclosures.

You may receive information about disclosures of your health information going back for six (6) years from the date of your request, but not earlier than April 14, 2003 (the general date that the HIPAA privacy rules became effective). You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to access electronic records. You may request access to electronic copies of your PHI, or you may request in writing or electronically that another person receive an electronic copy of these records. The electronic PHI will be provided in a mutually agreed-upon format, and you may be charged for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to opt-out of any fundraising activities. You may be contacted for purposes of fundraising activities, but you have the right opt-out of receiving such communications.

How to Exercise Your Rights in This Notice, File a Complaint and Additional Information

To exercise your rights listed in this notice, or to request additional information, or if you believe that your privacy rights have been violated, you should contact:

Privacy Officer
The City of San Diego Flexible Benefits Plan
1200 3rd Avenue, Suite 1000
San Diego, CA 92101
619.236.5924
FAX: 619.533.4077

You may also file a complaint with the regional Office for Civil Rights of the United States Department of Health and Human Services. Information on how to file a complaint is available on the Department of Health and Human Services website at www.hhs.gov/ocr/hipaa/

You will not be retaliated against for filing a complaint.

NOTICE OF MEDICARE AND PRESCRIPTION DRUG COVERAGE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The City of San Diego and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of San Diego has determined that the prescription drug coverage offered by HealthNet Kaiser, and/or Sharp Health plans is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage. Any employee enrolled in one of these plans that is eligible for Medicare is enrolled in a Part D plan through the medical plan and should not enroll for a separate Medicare prescription drug plan. If you do you will be disenrolled from the City sponsored medical coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in another Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th (subject to change). Beneficiary's leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan outside of the City's medical plan you are enrolled in, you will be dropped from the City's medical plan.

You should also know that if you drop or lose your coverage with the City of San Diego and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following open enrollment period to enroll.

NOTE: You will receive this notice annually and if this coverage through the City of San Diego changes. You also may request a copy.

For more information about this notice or your current prescription drug coverage contact Risk Management-Benefits at 619-236-5924.

NOTE: You will receive this notice annually and if this coverage through the City of San Diego changes. You also may request a copy. For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: June 2013
Name of Entity/Sender: The City of San Diego
Contact-Position/Office: Benefits Administrator
Risk Management
Address: 1200 3rd Avenue, Ste 1000,
San Diego, CA 92101
Phone Number: 619-236-5924

ADDITIONAL INFORMATION

Your Rights as a Plan Participant

San Diego, CA 92101
(619) 236-5924

As a participant in the Plan, you are entitled to certain rights. You may:

- examine, without charge, all plan documents (including insurance contracts)
- obtain copies of those plan documents at a reasonable cost
- obtain other Plan information upon request to the Plan Administrator (see THE PLAN ADMINISTRATOR section in this handbook for the address and telephone number).

Available Brochures and Applications

The information in this handbook is summarized for your convenience. More information can be found on CityNet.

Changing or Ending the Plan

The City reserves the right to change the Plan from time to time in order to meet the requirements of Federal law or changes brought about through negotiations with Employee Groups. In no event will the Plan be amended so that your contributions or benefit payments go to pay for anything but your benefits under this Plan.

The City also reserves the right to end the Plan, subject to negotiations with Employee Groups. The date the Plan would end must be agreed upon by the City and the Employee Groups. In no event will the funds used to provide benefits for you and your family be returned to the City. These funds must be used to provide benefits for you and your family only.

The Plan Administrator

The Employee Benefits Division of the Risk Management Department is the Plan Administrator. The Plan Administrator's primary responsibility is to manage the Flexible Benefits Plan according to the terms of the Plan Document. The Plan Administrator reserves the right to determine eligibility and construe the terms of the Plan, subject to the collective bargaining agreements in effect.

If you have any questions about the Flexible Benefits Plan, you should call or write the Risk Management Department at:

1200 Third Avenue, Suite 1000

FREQUENTLY ASKED QUESTIONS

1. I MISSED THE OPEN ENROLLMENT DEADLINE DATE AND I WANT TO MAKE A CHANGE TO MY BENEFITS. CAN I MAKE A CHANGE TO MY BENEFITS SELECTIONS AFTER OPEN ENROLLMENT?

IRS guidelines state that *no* benefit selection *changes* can be made *after* the plan year begins (July 1). The City must adhere to the IRS Section 125 Cafeteria Plan regulations otherwise it jeopardizes the City's ability to offer *pre-tax* benefits to its employees.

IRS makes an exception to the rule should any of the following occur:

- Marriage
- Divorce or legal separation or annulment
- Death of Spouse or Dependent
- Birth or Adoption of Child
- Gain or Loss of Insurance coverage
- Court Order
- Classification change affecting labor organization representation

In the event one of these situations occurs contact the Flexible Benefits Plan Section at (619) 236-5924 within **30 days** of the event. The document to prove the change in status is *required* and submitted to the Flexible Benefits Plan Section at MS #51E to allow the change.

The plan will also allow a HIPAA special enrollment for employees and dependents (including domestic partners, civil union partners or same sex spouses) who are eligible but not enrolled if they lose Medicaid or CHIP coverage because they are no longer eligible, or they become eligible for a state's premium assistance program. Employees have sixty (60) days from the date of the Medicaid/CHIP event to request enrollment under the Plan. If you request this change, coverage will be effective the first of the month following your request for enrollment.

2. WHAT HAPPENS IF I MISSED THE 30 DAYS DEADLINE TO ENROLL OR CHANGE MY BENEFITS?

As stated above, enrollment or changes to an employee's benefit is *limited* during the **open enrollment** period or within **30 days** of a qualified event. If enrolling for the first time and misses the 30 days deadline, the employee will only be allowed to enroll for the following *required* benefits:

- Basic Life Insurance
- Medical Insurance for *employee only coverage*

Dependents *cannot* be enrolled or added to the medical plan until the next open enrollment period. Enrollment or changes to the optional benefits (i.e. Dental Insurance; Vision Insurance; FSA Dental/Medical/Vision Reimbursement; and FSA Dependent Care Reimbursement) is not allowed until the next open enrollment period.

3. WHAT DOES PRE-PAYMENT MEAN AND WHY DO I NEED TO MAKE A PRE PAYMENT FOR MY HEALTH PLANS?

Pre-payment means payment in **advance**. The City pays the health insurance providers for the coverage the month before the coverage is effective. The employee is required to pre-pay for his/her health insurance coverage premiums that are not paid for by the City.

As an example, if you are a new hire or newly eligible employee for benefits in July, you are eligible to sign up for health and life insurance coverage effective August 1. A new hire or newly eligible employee is allowed to skip *one* month coverage if the employee cannot afford to make a pre-payment. You will be asked by the Benefits Representative as to when you want your coverage to begin. If you did not receive a paycheck from the City in July or if the deduction for health benefits has not been deducted because you recently became eligible for benefits, you will be asked to make a pre-payment for August coverage. The pre-payment can be deducted from your paycheck provided there are enough earnings to cover it. Otherwise, you can be billed via an invoice for the "full" cost of pre-payment.

NOTE: The health insurance providers do *not* allow *delay or lapse* in coverage for a qualified status change (marriage, divorce, birth, etc.).

4. CAN I USE MY “CITY FBP CREDITS” TO PRE-PAY FOR MY HEALTH INSURANCE COVERAGE?

No, you *cannot* use your “City FBP Credits” to pre-pay for your health insurance coverage because the City FBP Credits are received only after you have worked at least **40 hours** in a pay period. FBP Credits are **not** paid in *advance*.

5. CAN I ADD MY DEPENDENTS AT ANY TIME?

You may add your qualified dependents at any time provided there is a qualifying event such as: marriage; divorce; cancellation of health coverage due to termination of employment or spouse’s open enrollment; or end of COBRA eligibility. You must contact the Flexible Benefits Plan Section at (619) 236-5924 when any of these situations occur if you want to add your dependent. The proof of qualifying event is *required* to allow the dependent to be added to the health plans.

6. CAN I CANCEL MY DEPENDENTS COVERAGE AT ANY TIME?

Yes, you may cancel your dependents at any time even though there’s *no* qualifying event. Your dependents coverage will end on the last day of the month in which they were reported or date of qualifying event. If you wish to add them back to your health plans, there must be a qualifying event. Proof of qualifying document is *required*. Otherwise, they can only be added during the next open enrollment period. Contact the Flexible Benefits Plan Section at (619) 236-5924 if you want to cancel your dependents coverage.

7. WHY CAN’T I USE A POST OFFICE (P.O.) BOX AS MY BENEFITS ADDRESS?

The HMO insurance providers *require* an employee to live within a 30 mile radius from their medical facility. If a P.O. Box address is provided, the HMO insurance providers cannot determine if you actually reside within the 30 miles radius. This is important especially if you have an emergency. The HMO insurance providers can *deny* your application to enroll for their plan if you don’t live within the 30 miles radius.

8. WHY DOES THE CITY REQUIRE ME TO SUBMIT MY MARRIAGE CERTIFICATE, COPY OF DEPENDENT’S BIRTH CERTIFICATE, COPY OF DEPENDENT’S SOCIAL SECURITY CARD AND FEDERAL TAX RETURNS?

The City must ensure that all dependents enrolled for the benefit plans are eligible. These documents provide the required information to allow dependents to be enrolled. Until these documents are provided you will not be able to enroll your dependents. This ensures that only qualified dependents are enrolled and helps to control the cost of the insurance plans and the employees receive the appropriate FBP credits.

9. WHAT HAPPENS TO MY BENEFITS IF I DID NOT WORK OR DIDN’T HAVE 40 HOURS IN A PAY PERIOD?

If you did *not* work or was *not* in a paid leave status of at least 40 hours in a pay period, your City FBP Credits is *not* paid. The SAP system will try to collect the “full” cost of health insurance premiums if you received a paycheck.

You will receive a letter from the Flexible Benefits Plan Section staff asking you if you wish to continue your health and life insurance coverage when your insurance premium is *not* paid in a pay period. You are required to respond within **14 days** from receipt of the letter. Failure to respond will *automatically* cancel your health insurance coverage. Any services incurred during the period that your health coverage is canceled will be *your* responsibility. If you wish to have your insurance reinstated because you failed to respond within 14 days, it will be subject to approval by the insurance companies.

If you and your dependents have portable term life insurance and elected not to continue to pay for the coverage, the portable term life coverage will be canceled. When you return to work, you and your dependents will have

to re-apply for me the coverage and submit proof of good health. Coverage is subject to approval by the insurance company.

For the Flexible Spending Accounts (FSA) Dental/Medical/Vision and Dependent Care Reimbursement, per IRS Section 125 regulations, you are **not** allowed to cancel your contributions for the plan year. If you return to work within the same fiscal year of enrollment to a FSA account, your remaining contribution amount will be divided by the remaining pay periods in a fiscal year. Therefore, your biweekly contribution amount will increase.

10. WHAT HAPPENS TO MY FLEXIBLE BENEFITS PLAN ALLOTMENT IF I DID NOT USE IT ALL FOR MY HEALTH INSURANCE BENEFITS?

You don't have to use all of your Flexible Benefits Plan Allotment because it appears on your **biweekly** paycheck as "**City FBP Credits**" and it is added to your "Earnings".

11. WHAT CAN I DO TO MAKE MY BIWEEKLY "CITY FBP CREDITS" NOT BE REPORTED AS TAXABLE INCOME?

When you enroll for the following **pre-tax** benefits: a) health insurance; b) flexible spending accounts (dental/medical/vision or dependent care); 401 (k); and deferred compensation plans, your reported taxable income, which includes the City FBP Credits, is **reduced**. Therefore, your federal and state taxes are **reduced**.

To find out if your City FBP Credits affected your taxable income, you need to take the biweekly "City FBP Credits" and "Total Pre-Tax Deductions" listed on your paycheck.

- If the "Total Pre-Tax Deductions" is more than the "City FBP Credits", your taxable income has been reduced and your City FBP Credits are not taxable.
- If the "Total Pre-Tax Deductions" is less than the "City FBP Credits", your taxable income is increased by the difference.

To **reduce** your taxable income, you may also contribute to the following **pre-tax** plans: a) FSA DMV; b) FSA DCC; c) 401(k); and d) Deferred Compensation.

NOTE: FSA Dental/Medical/Vision and Dependent Child Care are "**Use**" or "**Lose**" plans. Do **NOT** contribute to these plans if you do **not** have any dental, medical, vision or dependent care expenses to incur within the fiscal year because contributions **cannot** be rolled over to the next plan year and if you do not file an eligible claim with the necessary receipts, you "lose" the money that was contributed to your account.

REMINDER: Your pre-tax deductions such as: a) health insurance and b) flexible spending accounts in excess of your City FBP Credits **reduces** your SPSP contribution and the City's matching contribution, if it is applicable to you.

12. IF I AM CONTRIBUTING TO A FLEXIBLE SPENDING ACCOUNT (FSA) , HOW DO I GET REIMBURSED?

To get reimbursed for the Flexible Spending Account for Dental/Medical/Vision and Dependent Child Care, you need to follow this procedure:

- a. **Enter** your claim through the OneSD Employee Self-Service (ESS) portal page.
- b. **Scan** the receipt or Explanation of Benefits (EOB) to support your claim. (NOTE: Please make sure that the scanned receipt is **readable** and has **ALL** the required information)
- c. **Email** the scanned receipt or EOB to the **Reimbursement Administrator** listed on the City's Outlook Contacts.

The Benefits Representatives will review your claim when the receipts and/or Explanation of Benefits to support your claim have been received. You can view your claim history and actions that has been done to your claim on ESS. If your claim has **not** been processed **six (6) weeks** from the date you submitted the scanned receipts/statement, please email the Reimbursement Administrator for follow up.

13. WHAT BENEFITS CAN I CONTINUE IF I LEAVE CITY EMPLOYMENT?

The Consolidated Omnibus Budget Reconciliation Act (COBRA), a Federal law, requires employers such as the City, to offer the employee and its dependents continuation of health insurance coverage for an 18 or 36 months. The 18 month coverage is for employees (and their dependents) who leave City employment. The 36 month coverage is for the employee's spouse upon divorce or death of employee or coverage dependents. Please refer to the COBRA Section of the Flexible Benefits Summary Highlights for further details.

14. AM I ENTITLED TO CITY PAID BENEFITS IF I AM ON MILITARY LEAVE?

Yes, you are entitled to City FBP Credits when you are on a **30 day** military leave assignment. After the 30 day military leave assignment, you are *not* entitled to City FBP Credits *unless* it is due to Presidential Military Leave Order. You will need to provide your Payroll Specialist a copy of your military leave orders. Your Payroll Specialist will provide the information to Personnel, Payroll and Risk Management.

You are allowed to waive your medical insurance if you are *not* a MEA or Local 911 classified employee. If you wish to continue your medical coverage because you have dependents enrolled, you will receive an invoice in the mail to have your premium paid for your dependents. It would be helpful to assign a Power of Attorney to your spouse or family member that you trust to handle your affairs, such as benefits and payroll with the City.

The City FBP Credits that you earned while on Military leave will be reflected on your paycheck when you return to work.

15. WHEN I AM ON FAMILY MEDICAL LEAVE OR PREGNANCY DISABILITY OR CFRA, ARE MY BENEFITS PAID FOR BY THE CITY?

You are entitled to City FBP Credits up to the cost of "employee" only coverage, whichever is less, for a total of 12 weeks. The 12 weeks period (480 hours for full-time employee) counts from the first day you took a day off related to the family medical leave. It runs concurrent with any paid leave such as: a) annual leave; b) industrial leave; c) long-term disability; d) worker's compensation; and e) total temporary disability.

A copy of the approved Family Medical Leave application has to be submitted to Risk Management, MS # 51E or emailed to **RMGT Benefits Administrator** for benefits determination.

16. HOW CAN I GET A COPY OF MY BENEFITS SELECTIONS FOR THE FISCAL YEAR?

You can print a copy of your benefits selections or Confirmation Statement by logging in to ESS portal page, then click on the Benefits Tab and click on the Participation Overview link.

17. WHERE DO I GET THE LIST OF BENEFITS AVAILABLE TO ME FOR THE NEW FISCAL YEAR?

You can print a copy of the benefits selections for the new fiscal year by logging in to ESS portal page, then click on the Benefits Tab and click on the Open Enrollment link.

18. WHEN AND HOW CAN I ENROLL FOR PORTABLE TERM LIFE INSURANCE?

Portable term life insurance enrollment is open at any time. You must complete and submit to Risk Management, Benefits, at MS # 51E, a life insurance application form and Proof of Good Health form. The life insurance application form and Proof of Good Health form will be forwarded to the Life Insurance company for the underwriting and approval process.

19. WHEN CAN I INCREASE MY PORTABLE TERM LIFE INSURANCE ONE LEVEL UP WITHOUT COMPLETING A PROOF OF GOOD HEALTH FORM?

During the open enrollment period you are allowed to increase your portable term life insurance one level without completing a Proof of Good Health form, up to the simplified issue amount (**\$250,000** for less than 60 years old or **\$50,000** if 60 years old or more). If the life insurance application form is received past the open enrollment period deadline, the employee will be *required* to complete and submit the Proof of Good Health form and the increase will be subject to approval by the Life Insurance company.

20. HOW DO I KNOW IF MY OR MY DEPENDENTS PORTABLE TERM LIFE HAS BEEN APPROVED?

The Life Insurance company will send you an approval or denial letter in the mail. A copy of the approval or denial letter is sent to Risk Management for payroll processing. Once the approval letter has been received by Risk Management, the Benefits Representative enters the information into the system to start the payroll deduction. You have to verify the portable term life deduction on your paycheck. If the portable term life deduction is not reflected on your paycheck, please call the Flexible Benefits Plan Section at (619) 236-5924 to verify if the approval letter has been received.

21. WHEN AND WHERE CAN I ENROLL FOR 401(K) OR DEFERRED COMPENSATION?

Enrollment or Change to the 401(k) and Deferred Compensation plan is available at any time. You will need to log in to ESS portal page, click on the Benefits tab, and click on Anytime Savings plans. Select the plan you wish to enroll or edit. Save your enrollment and changes. A copy of your enrollment or change can be printed at anytime for confirmation.

22. WHO CAN I ADD AS MY FAMILY MEMBER/DEPENDENT IN EMPLOYEE SELF SERVICE (ESS)?

You can list anyone, including your friend, as your family member/dependent. You also would list your Living Trust in this area if you are designating it as your beneficiary.

23. IF I LIST MY FAMILY MEMBER/DEPENDENT INFORMATION IN EMPLOYEE SELF SERVICE (ESS), WHAT IS IT USED FOR?

The Family Member/Dependent is where you enter the information for the following:

- To enroll your qualified dependents for your medical, dental, vision or life insurance and flexible spending accounts for dental/medical/vision and dependent care reimbursements
- Beneficiary for your life insurance plans
- Beneficiary for your savings plans such as: SPSP; 401(k); 401(a); and Deferred Compensation

24. WHAT DOES CONTINGENT BENEFICIARY MEAN?

Contingent beneficiary means the beneficiary you would designate just in case your primary beneficiary is deceased and you have not updated your primary beneficiary information.

25. CAN I NAME MORE THAN ONE PRIMARY OR CONTINGENT BENEFICIARY?

Yes. You will have to designate the percentage of distribution to your primary or contingent beneficiaries. The distribution total must be 100 percent.

26. HOW OFTEN CAN I CHANGE MY BENEFICIARIES?

Beneficiaries can be updated at any time through ESS. We recommend that you update your beneficiaries every time you have a life event change such as marriage or divorce.

27. I ENROLLED FOR THE DENTAL/MEDICAL/VISION REIMBURSEMENT PLAN FOR THE FISCAL YEAR AND FOUND OUT THAT I WILL NOT BE USING IT, CAN I CANCEL MY ENROLLMENT?

No. Once you enroll for the dental/medical/vision reimbursement plan, you are not allowed to change or cancel your contribution even though you have a change in family status. Any unused monies will be forfeited. If you are not sure if you will spend the money you allocate for this reimbursement plan within the plan year or don't want to have to submit claims to receive the money it is recommended that you do **NOT** enroll for this plan.

28. I ENROLLED FOR THE DEPENDENT CHILD CARE REIMBURSEMENT PLAN FOR THE FISCAL YEAR AND MY CHILD WILL NO LONGER BE IN DAY CARE DUE TO MY SPOUSE'S LOSS OF EMPLOYMENT, CAN I CANCEL MY ENROLLMENT TO THE DEPENDENT CHILD CARE REIMBURSEMENT?

Yes. Per IRS Section 125 regulations, an employee cannot be reimbursed for the dependent child care reimbursement if the spouse is not working or a student. IRS allows the dependent child care reimbursement to be canceled if this situation occurs. You have 30 days from the date of the qualifying event to inform the Flexible Benefits Plan Section at (619) 236-5924 and have the contribution stopped.

29. CAN I TRANSFER MONEY FROM MY DENTAL/MEDICAL/VISION REIMBURSEMENT ACCOUNT TO MY DEPENDENT CARE REIMBURSEMENT ACCOUNT OR VICE-VERSA?

No. Because of IRS regulations, each account is set up separately and the funds cannot be mixed.

30. WHAT HAPPENS TO MY REIMBURSEMENT ACCOUNTS IF I LEAVE MY JOB MID-YEAR?

You may submit claims up to 30 days after termination for expenses you incurred while eligible for the reimbursement option. An option to continue the flexible spending account for dental/medical/vision is available under the COBRA plan by paying the monthly premium plus 2% administrative fee. A COBRA letter will be mailed to you to notify you about the plans available for continuation. If you decide to continue to contribute to the plan, an invoice will be sent until the plan year ends or when you elect to cancel.

31. MY SPOUSE IS ENROLLED IN A FLEXIBLE SPENDING ACCOUNT WITH HIS/HER EMPLOYER. CAN I USE THE SAME RECEIPTS FOR REIMBURSEMENT?

No. If a receipt has been submitted for reimbursement from another employer, the employee *cannot* submit the same receipt for reimbursement or claim the same receipt on the federal income tax return because your spouse has already taken advantage of the pre-tax benefit.

32. WHAT IS THE DEADLINE DATE TO USE THE SERVICES AND SUBMIT A REIMBURSEMENT CLAIM FOR THE CURRENT PLAN YEAR?

The last date to use the *services* for the current plan year is June 30 or last day of employment whichever comes first. The deadline date to *enter* a reimbursement claim for the current plan year is July 31. If the plan year ends on a weekend (Saturday or Sunday) and you don't have access to log in a City computer, you need to enter the reimbursement claim through ESS by your last working day in July.

NOTES
