THE CITY OF SAN DIEGO

FISCAL YEAR 2016 OPEN ENROLLMENT INFORMATION AND COSTS

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FY 2016 IMPORTANT TIPS AND INFORMATION

Open enrollment begins on **Monday, June 15th and ends on Tuesday, June 30th before midnight**.

Enrollment changes are done via Employee Self Service (ESS) in the SAP system at your worksite. To have a smooth open enrollment experience, please follow the instructions below:

a. Watch the appropriate Open Enrollment video found on CityNet under the Pay & Benefits tab. There are two videos:
    1. Link for POA members - https://youtu.be/WW25SufG8Fs
    2. Link for All Non-POA - https://youtu.be/a77pStHaYOU.
b. **All employees must** acknowledge the Benefits Consent located at ONESD>ESS>Benefits>Benefits Consent. You must Review and Send before exiting.
c. Gather your tools that will assist you:
    1. Print and review your FY 2015 benefits through ONESD SAP > ESS> Benefits> Participation Overview
    2. On CityNet under the Pay & Benefits tab obtain the Open Enrollment Worksheet
    3. On CityNet under the Pay & Benefits tab obtain FY 16 Open enrollment Information and Costs booklet
    4. Review the provider information on CityNet under the Pay & Benefits tab.
d. If you have questions about a plan, contact the plan at the number listed in the Open Enrollment Information and Costs booklet (last page) before open enrollment ends.
e. **If you made a change** to your Benefit selection(s) make sure you click the review and save buttons for your changes to apply before you exit ESS. **If you do not make** a change to any of your health selections, do not click the Save button before exiting ESS. If you mistakenly click the Save button, please talk to a Flexible Benefits staff member at (619) 236-5924.
f. Print and review your Confirmation Statement. You can make changes to your benefits as many times as you need before the open enrollment ends on June 30th, 2015. Make sure you **print** and **review** your Confirmation Statement every time you make a change.

This material in this booklet is a quick reference guide that employees can refer to throughout the fiscal year especially if there's a qualified status event. It is updated annually.

The Flexible Benefits Plan Summary Highlights Booklet, located on the CityNet, provides all other information regarding the Flexible Benefits Plan program.

PLEASE NOTE: The Flexible Benefits Credits and Medical/Dental/Vision dollars in the Open Enrollment Information and Costs booklet are rounded when changing from monthly to annual or annual to monthly.
If you have any questions regarding your benefit options or need assistance enrolling, please contact Employee Benefits at 619-236-5924.

OPEN ENROLLMENT REMINDERS AND PERTINENT PLAN INFORMATION

ESS

Instructions on how to enroll for benefits is posted on CityNet>Pay & Benefits>How To Enroll link. If you need assistance in enrolling for benefits through ESS, please see your Payroll Specialist or contact Flexible Benefits staff at (619) 236-5924.

DEPENDENT CHANGES

In ESS go to Personal Information>Family Member/Dependents to verify, add or change your dependents listed. The family member/dependent information **cannot** be deleted if the dependent is enrolled in a benefit plan or named as beneficiary. If you need to delete a family member/dependent, contact Benefits staff at (619) 236-5924.

ON LEAVE OR VACATION DURING OPEN ENROLLMENT

If you wish to make changes to your benefits, but do not have access to a City computer or access to ESS, please contact Beth Monillas or Michael Williams at (619) 236-5924 immediately upon your return to work.

If you are on Long-Term Disability, Industrial Leave or Leave of Absence Without Pay and continue to pay for health insurance, you need to make the change to your benefits during the open enrollment period. The open enrollment materials (i.e. open enrollment memo, FBP Credits and Health Plan rates) will be mailed to your home address. Please contact Benefits staff at (619) 236-5924 if you need to make a change to your benefits before the open enrollment period ends. When you return to work, the same benefits that you made during the open enrollment period will continue.

HMO PROVIDER INFORMATION

If enrolling for HMO plans (except Kaiser) make sure to enter the medical or dental physician code for yourself and dependents in ESS. This information is sent to the plan to inform them of your selection. If this code is blank the plan will assign you and/or your dependents to a provider nearest to your home. In the event you wish to seek treatment with a different provider, you need to contact the insurance plan and request a provider change.

BASIC AND PORTABLE TERM LIFE INSURANCE

The City requires employees to be enrolled in Basic Term Life Insurance. During open enrollment, employees represented by MEA, Local 127 and Teamsters can increase or decrease the level of Basic Term Life to $10,000, $25,000 or $50,000.

At any time, Portable Term life insurance is available to employees and family members. If an Evidence of Insurability (EOI) is needed, you will be contacted by The Hartford. The combined portable term coverage for family or other dependents exceed your combined Basic and Portable coverage.

The Hartford has enhanced services that you can check further in their brochure on CityNet. Such enhancements include: Estate Guidance Will Services; Express Pay; Travel Assistance with ID Theft Protection and Assistance; Beneficiary Assist Counseling Services; Funeral Planning and Concierge includes Everest Services with a funeral-related cost comparison tool.

REIMBURSEMENT CLAIMS

If you contribute to the Dental/Medical/Vision Reimbursement or Dependent/Child Care Contribution option for FY 2016, ***services*** must be incurred by **June 30, 2016**. FY 2016 claims must be entered in ESS by **July 31, 2016.** Late claim entries in ESS will be rejected. The receipts/statements have to be scanned and emailed to Reimbursement_Admin@sandiego.gov.

> The maximum amount of Salary Reduction Contributions and Non-elective Employer Contributions that a Participant may elect to allocate to this benefit is $2,550 for any Plan Year. The minimum amount that a Participant may elect to contribute with respect to any Plan Year is $260.

Paper reimbursement forms will not be accepted and will be returned. The only exception is if the employee has no access to a City computer. If this is the case, please write the reason why a paper claim is submitted.

Remember, this is a use or lose option. All unclaimed monies will be forfeited. Your claim balance and claims history can be viewed through Employee Self Service (ESS). If you need assistance entering your claim via ESS contact Flexible Benefits staff at (619) 236-5924.

BENEFICIARIES

Beneficiary designation for life insurance and all savings plans is available through ONESD/SAP>ESS> Benefits>Anytime Beneficiaries. Be sure to periodically check your beneficiaries and make any changes when you have a life event change (e.g. marriage, divorce, new family member, etc.).

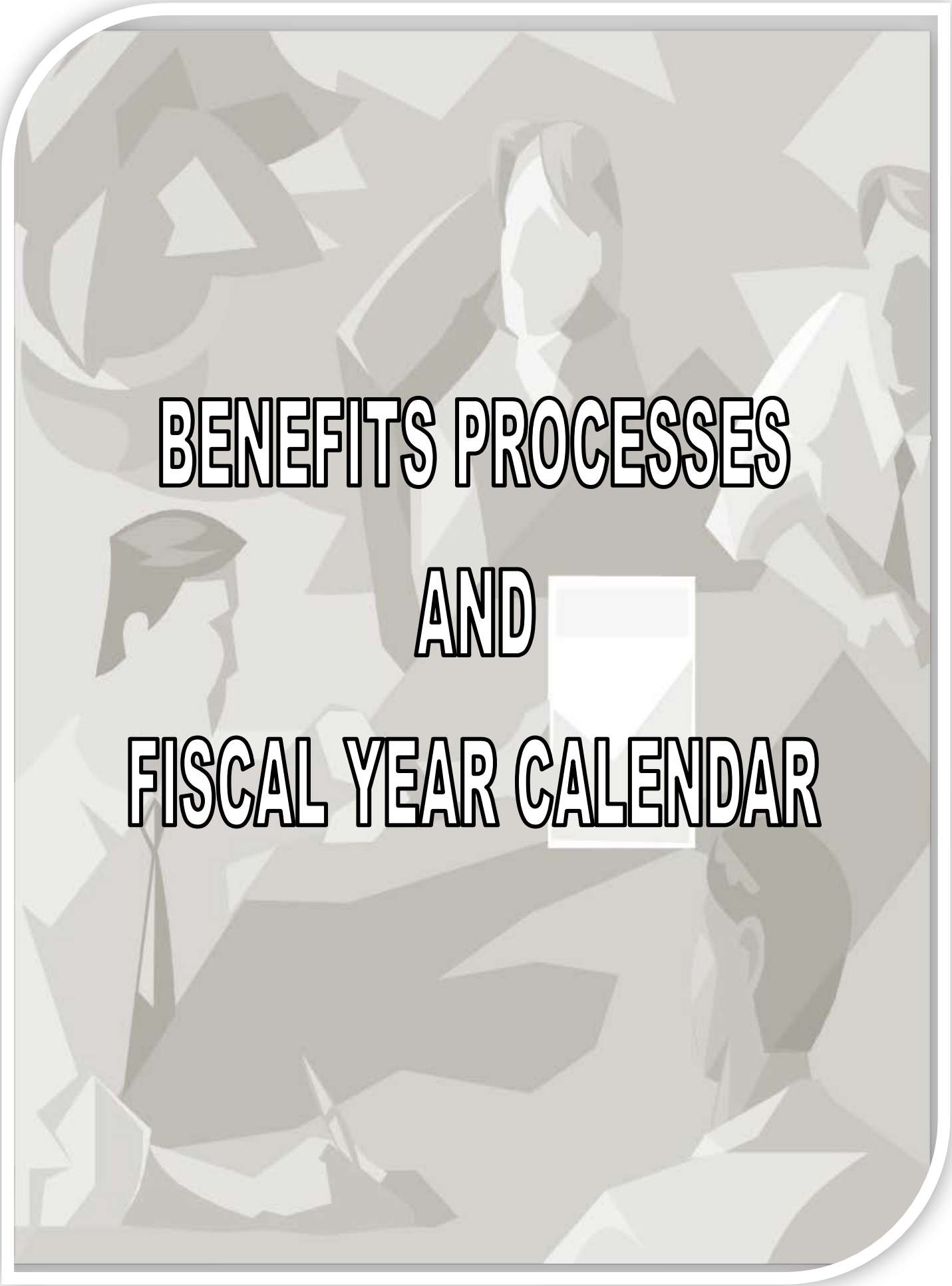
QUALIFYING EVENT CHANGES

In the event you have a qualifying event change (e.g. marriage, divorce, birth or adoption of a child, gain or loss of coverage, job class change or court order, etc.), please contact Flexible Benefits staff at (619) 236-5924 or send an email to Benefits_Admin@sandiego.gov within **30 days** from date of event to allow you to make the necessary changes to your benefits. Proof of qualifying event will be **required**. If you miss the 30-day deadline, your request to change your benefits could be denied and you will have to wait until the next open enrollment period for the change to be effective.

401(k)/DEFERRED COMPENSATION PLANS

The maximum amount that you can contribute to the 401(k) and Deferred Compensation plans for calendar year 2015 is $18,000 for each plan. If you are 50 years of age or older by December 31, 2015, you may also be eligible to contribute an additional $6,000 to each plan.

Payroll Changes to 401(k) or Deferred Compensation is done through ONESD>ESS>Benefits>Anytime Savings. Be sure to enter the **bi-weekly** amount you want to contribute, not the annual amount. Your changes for 401(k) take effect the pay period in which you enter them in SAP. For example, if you make a change to your 401(k) contribution the first day of open enrollment (June 15th) it will be reflected on your 7/3/15 paycheck. If you want it to be effective on your July 17th paycheck, you will need to make the change via ESS between 6/20/15 and 7/3/15. A change to the Deferred Compensation contribution will not take effect until the next month (if the change request is made in June the contribution change will occur in July).



BENEFITS PROCESSES AND FISCAL YEAR CALENDAR

BENEFITS PROCESSES FLOW

ENROLLMENT, CHANGES & CANCELLATIONS

MUST BE REPORTED WITHIN 30 DAYS FROM DATE OF EVENT

NEW HIRE, NEWLY ELIGIBLE OR REHIRE

- ☞ Attend Benefits Orientation
- ☞ Provide Marriage Certificate & Birth Certificates to Enroll Dependents.

→

- ☞ Enroll through ESS.
- ☞ Print & Review Confirmation Statement.
- ☞ Print & Review Payroll Statement with Benefits Deduction.

OPEN ENROLLMENT

- ☞ Print & review FY 15 Current Selection.
- ☞ Review Benefits & Rate Changes.
- ☞ Discuss Benefits with Family.

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- ☞ Change enrollment through ESS during Open Enrollment Period.
- ☞ Print & Review FY 16 Confirmation Statement.
- ☞ Print & Review first fiscal year Payroll Statement with Benefits Deduction.

FAMILY STATUS CHANGE
(Ex. Marriage, Divorce, Birth, Gain or Loss of Coverage)

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- ☞ Report Status Change within 30 days to Flexible Benefits Staff at (619) 236-5924.

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- ☞ Provide Proof of Qualified Status Change (i.e. Marriage Certificate, Birth Certificate, Statement to confirm Gain or Loss of Coverage)

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- ☞ Change enrollment through ESS within 30 days from Event.
- ☞ Print & Review Confirmation Statement.
- ☞ Print & Review first Payroll Statement with Benefits Deduction.

EMPLOYEE GROUP CHANGE
(Ex. MEA to Unrep)

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- ☞ Report Status within 30 days to Flexible Benefits Staff at (619) 236-5924.

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- ☞ If eligible, change enrollment through ESS within 30 days from Event.
- ☞ Print & Review Confirmation Statement.
- ☞ Print & Review first Payroll Statement with Benefits Deduction.

LEAVE OF ABSENCE

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- ☞ Flexible Benefits Staff will inform employee via US mail the option to pay for health & life insurance coverage.

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- ☞ Employee responds to letter by stating benefit plans to continue or cancel.

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- ☞ If employee continues benefits coverage, an invoice will be issued to collect premium payment.
- ☞ After one (1) year, eligible for 18 months COBRA.

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- ☞ If employee cancels coverage, it will be reported to insurance providers.
- ☞ Employee cannot enroll until he/she returns to work.

LONG TERM DISABILITY

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- ☞ Employee applies for LTD Benefits. If approved, there's a 30-days waiting period.

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- ☞ Eligible for 18 months COBRA after LTD benefits are exhausted.

FMLA, CFRA, PDA

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- ☞ Employee applies for FMLA, CFRA or PDA.

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- ☞ The employee may be entitled to paid life and health benefits not to exceed City FBP Credit, varies according to approved leave.

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- ☞ If denied, the employee can continue benefits as LWOP for one (1) year & 18 months COBRA after.

SEPARATION

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- ☞ Employee will receive COBRA package via US mail.
- ☞ Employee has 60 days to respond & 45 days to pay full cost of premium retroactive from date of termination of coverage.

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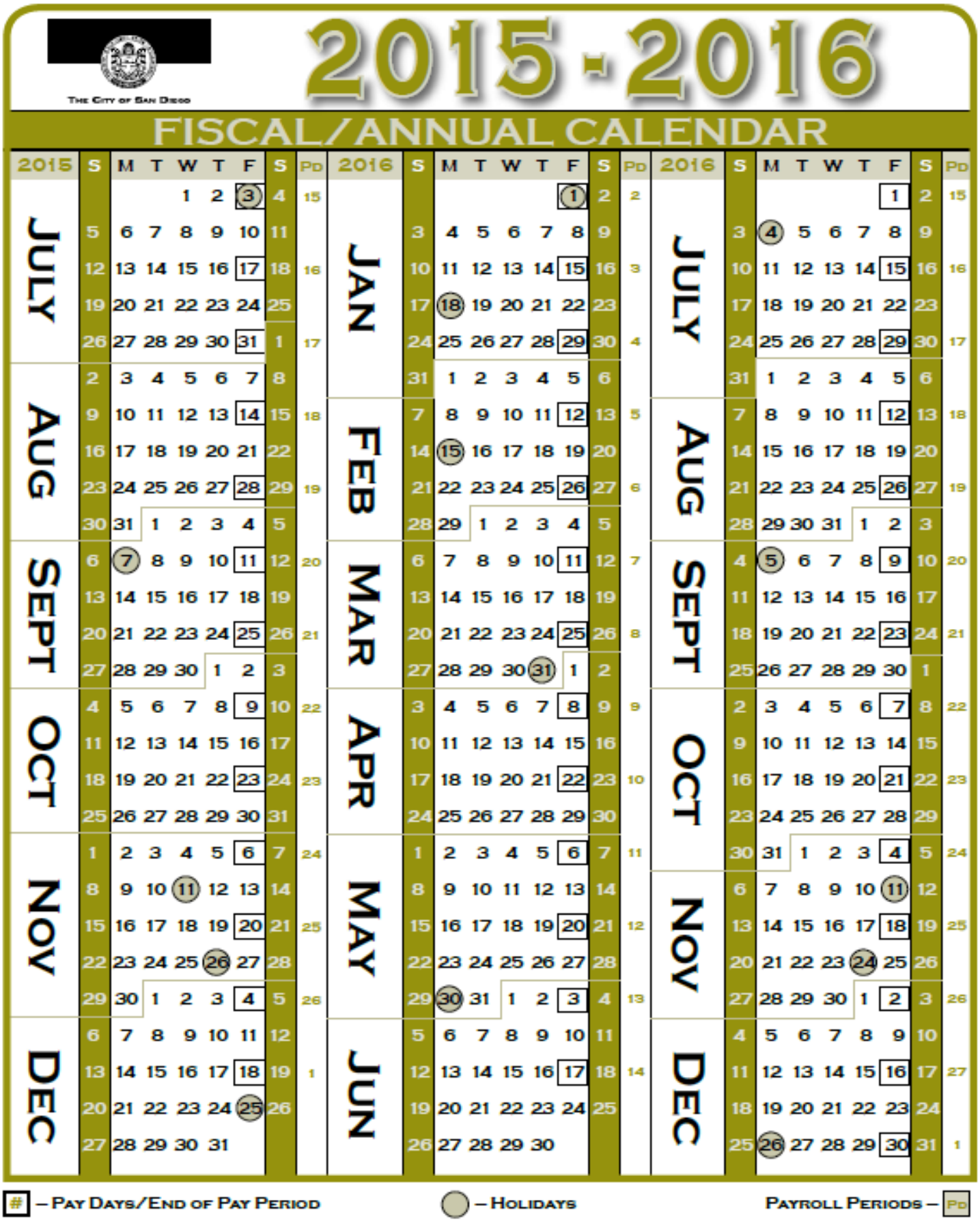
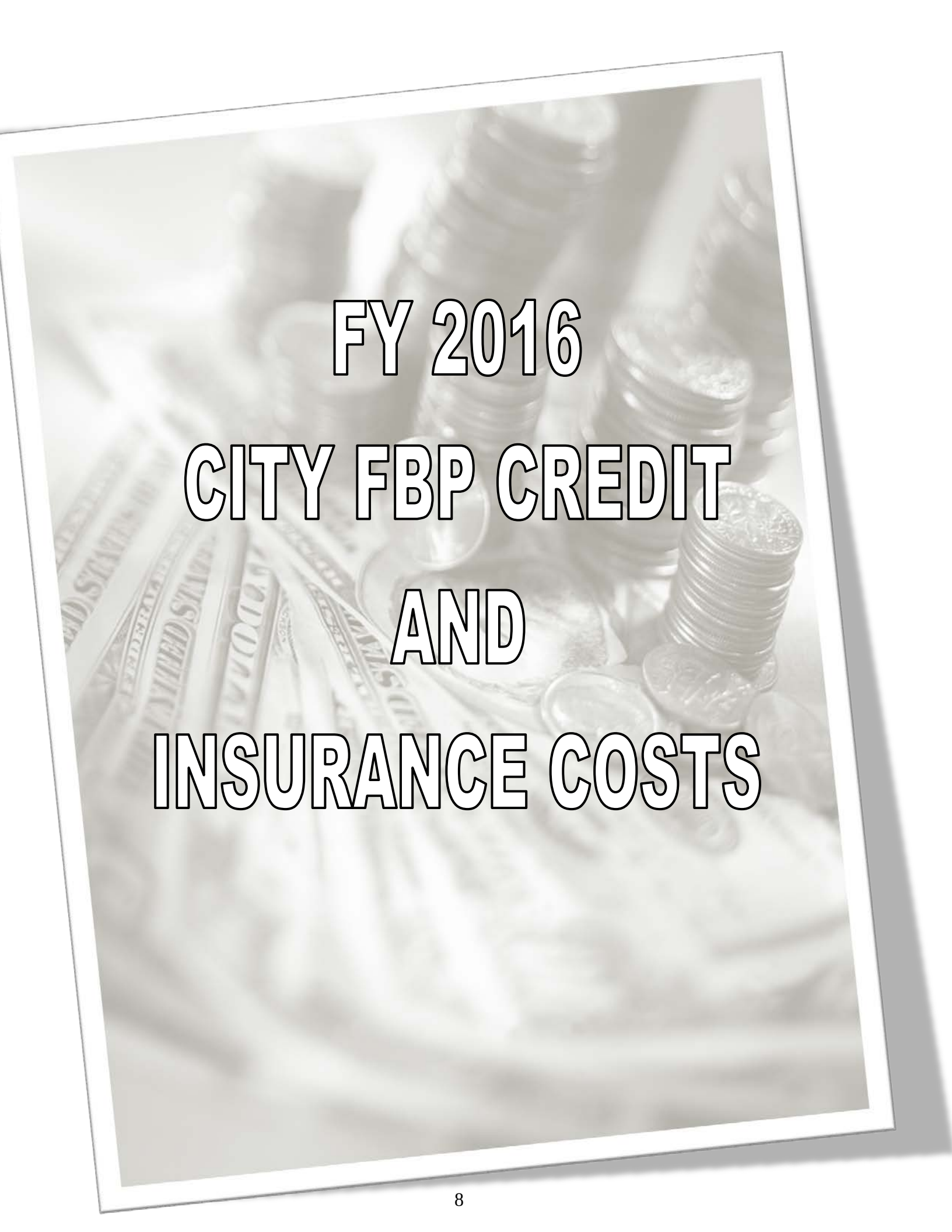
- ☞ An automatic monthly invoice will be issued.
- ☞ Opportunity to change benefits during open enrollment or qualified status change.
- ☞ Eligible for Cal-COBRA. Paid through Insurance Provider.

FISCAL YEAR CALENDAR





FY 2016 CITY FBP CREDIT AND INSURANCE COSTS

FY 2016 CITY FBP CREDIT

EMPLOYEE GROUP REPRESENTATION	ANNUAL	BIWEEKLY (26 PAY PERIODS)		
	FULL TIME TIME	1/2 TIME (40)	3/4 TIME (60)	FULL TIME (80 or 112)
MEA	$8,555	$329.04	$329.04	$329.04
TEAMSTERS – LOCAL 911	$10,311	$396.58	$396.58	$396.58
LOCAL 127				
Waive	$6,806	$261.77	$261.77	$261.77
Employee only	$7,806	$300.23	$300.23	$300.23
Employee & Spouse/Domestic Partner	$9,016	$346.77	$346.77	$346.77
Employee & Children	$8,356	$321.39	$321.39	$321.39
Employee & Spouse/Domestic Partner & Children	$10,056	$386.77	$386.77	$386.77
LOCAL 145				
Waive	$1,750			$67.31
Employee only	$8,180			$314.62
Employee & Spouse/Domestic Partner	$14,453			$555.89
Employee & Children	$11,803			$453.96
Employee & Spouse/Domestic Partner & Children	$16,447			$632.58
POA – less than 8 years of service				
Waive	$7,605			$292.50
Employee only	$9,942			$382.38
Employee & Spouse/Domestic Partner	$12,385			$476.35
Employee & Children	$11,919			$458.42
Employee & Spouse/Domestic Partner & Children	$16,700			$642.31
POA – 8 or more years of service				
Waive	$10,505			$404.04
Employee only	$12,842			$493.92
Employee & Spouse/Domestic Partner	$15,285			$587.88
Employee & Children	$14,819			$569.96
Employee & Spouse/Domestic Partner & Children	$19,600			$753.85
POA LIEUTENANTS AND CAPTAINS – less than 8 years of service				
Waive	$10,605			$407.88
Employee only	$12,942			$497.77
Employee & Spouse/Domestic Partner	$15,385			$591.73
Employee & Children	$14,919			$573.81
Employee & Spouse/Domestic Partner & Children	$19,700			$757.69
POA LIEUTENANTS AND CAPTAINS – 8 or more years of service				
Waive	$13,505			$519.42
Employee only	$15,842			$609.31
Employee & Spouse/Domestic Partner	$18,285			$703.27
Employee & Children	$17,819			$685.35
Employee & Spouse/Domestic Partner & Children	$22,600			$869.23
DCAA				
Waive	$6,292	$121.00	$181.50	$242.00
Employee only	$9,993	$192.18	$288.26	$384.35
Employee & Spouse/Domestic Partner	$13,504	$259.69	$389.54	$519.39
Employee & Children	$12,418	$238.81	$358.21	$477.62
Employee & Spouse/Domestic Partner & Children	$13,871	$266.75	$400.13	$533.50

FY 2016 CITY FBP CREDIT

EMPLOYEE GROUP REPRESENTATION	ANNUAL	BIWEEKLY (26 PAY PERIODS)		
	FULL TIME TIME	1/2 TIME (40)	3/4 TIME (60)	FULL TIME (80 or 112)
UNREPRESENTED/UNCLASSIFIED – SALARIED				
Waive	$6,827	$131.29	$196.93	$262.58
Employee only	$10,028	$192.85	$289.27	$385.69
Employee & Spouse/Domestic Partner	$13,026	$250.50	$375.75	$501.00
Employee & Children	$12,453	$239.48	$359.22	$478.96
Employee & Spouse/Domestic Partner & Children	$14,621	$281.17	$421.76	$562.35
UNREPRESENTED/UNCLASSIFIED – HOURLY				
Waive	$3,144	$60.46	$90.69	$120.92
Employee only	$6,345	$122.02	$183.03	$244.04
Employee & Spouse/Domestic Partner	$9,343	$179.68	$269.51	$359.35
Employee & Children	$8,770	$168.66	$252.98	$337.31
Employee & Spouse/Domestic Partner & Children	$10,938	$210.35	$315.52	$420.69

MEDICAL PLANS & COSTS

MEDICAL PLANS (REQUIRED)	ANNUAL*	MONTHLY	BIWEEKLY (26 PAY PERIODS)	
			POST-TAX	PRE-TAX
WAIVE MEDICAL WITH FEE – Available to MEA, Local 127 & Local 911				
Employee only	$18	$1.50	$0	$0.69
WAIVE MEDICAL WITHOUT FEE – Available to DCAA, POA, Local 145, Unrepresented & Unclassified				
Employee only	$0	$0	$0	$0
KAISER – Available to All Employees				
Employee only	$4,700	$391.64	$0	$180.76
Employee & Spouse	$10,293	$857.69	$0	$395.86
Employee & Domestic Partner (non-dependent)	$10,293	$857.69	$215.10	$180.76
Employee & Children	$8,930	$744.12	$0	$343.44
Employee & Spouse & Children	$14,288	$1,190.59	$0	$549.50
Employee & Domestic Partner & Children (non-dependent)	$14,288	$1,190.59	$206.06	$343.44
COSD HEALTH NET HMO – Available to DCAA, Local 127, Local 911, MEA, POA, Unrepresented & Unclassified				
Employee only	$12,619	$1,051.57	$0	$485.34
Employee & Spouse	$27,634	$2,302.79	$0	$1,062.83
Employee & Domestic Partner (non-dependent)	$27,634	$2,302.79	$577.49	$485.34
Employee & Children	$23,975	$1,997.91	$0	$922.11
Employee & Spouse & Children	$38,360	$3,196.66	$0	$1,475.38
Employee & Domestic Partner & Children (non-dependent)	$38,360	$3,196.66	$553.27	$922.11
COSD HEALTH NET PPO – Available to All Employees				
Employee only	$18,684	$1,556.96		$718.60
Employee & Spouse	$40,917	$3,409.72		$1,573.72
Employee & Domestic Partner (non-dependent)	$40,917	$3,409.72	$855.12	$718.60
Employee & Children	$35,498	$2,958.12		$1,365.29
Employee & Spouse & Children	$56,798	$4,733.10		$2,184.51
Employee & Domestic Partner & Children (non-dependent)	$56,798	$4,733.10	$819.22	$1,365.29
SHARP CLASSIC – Available to DCAA, Local 127, Local 911, MEA, POA, Unrepresented & Unclassified				
Employee only	$5,678	$473.11	$0	$218.36
Employee & Spouse	$12,434	$1,036.10	$0	$478.20
Employee & Domestic Partner (non-dependent)	$12,434	$1,036.10	$259.84	$218.36
Employee & Children	$10,787	$898.91	$0	$414.88
Employee & Spouse & Children	$17,259	1,438.23	$0	$663.80
Employee & Domestic Partner & Children (non-dependent)	$17,259	1,438.23	$248.92	$414.88
SHARP SELECT – Available to DCAA, Local 127, Local 911, MEA, POA, Unrepresented & Unclassified				
Employee only	$4,335	$361.21	$0	$166.71
Employee & Spouse	$9,493	$791.01	$0	$365.08
Employee & Domestic Partner (non-dependent)	$9,493	$791.01	$198.37	$166.71
Employee & Children	$8,236	$686.27	$0	$316.74
Employee & Spouse & Children	$13,176	$1,098.00	$0	$506.77
Employee & Domestic Partner & Children (non-dependent)	$13,176	$1,098.00	$190.03	$316.74

MEDICAL PLANS & COSTS

MEDICAL PLANS (REQUIRED)	ANNUAL*	MONTHLY	BIWEEKLY (26 PAY PERIODS)	
			POST-TAX	PRE-TAX
LOCAL 145 – ANTHEM BLUE CROSS – Available to Local 145 Classified & Unclassified				
Employee only	$7,136	$594.60	$0	$274.43
Employee & Spouse	$16,656	$1,387.99	$0	$640.61
Employee & Domestic Partner (non-dependent)	$16,656	$1,387.99	$366.18	$274.43
Employee & Children	$13,674	$1,139.47	$0	$525.91
Employee & Spouse & Children	$23,356	$1,946.29	$0	$898.29
Employee & Domestic Partner & Children (non-dependent)	$23,356	$1,946.29	$372.38	$525.91
POA ALADS CALIFORNIA CARE BASIC (NO Dental) – Available to POA Classified & Unclassified				
Employee only	$7,460	$621.62	$0	$286.90
Employee & Spouse	$14,568	$1,213.99	$0	$560.30
Employee & Domestic Partner (non-dependent)	$14,568	$1,213.99	$273.40	$286.90
Employee & 1 Child	$14,568	$1,213.99	$0	$560.30
Employee & Children	$18,027	$1,502.25	$0	$693.35
Employee & Spouse & Children	$18,027	$1,502.25	$0	$693.35
Employee & Domestic Partner & Children (non-dependent)	$18,027	$1,502.25	$133.05	$560.30
POA ALADS CALIFORNIA CARE PREMIER (With Dental) – Available to POA Classified & Unclassified				
Employee only	$8,920	$743.29	$0	$343.06
Employee & Spouse	$16.028	$1,335.66	$0	$616.46
Employee & Domestic Partner (non-dependent)	$16.028	$1,335.66	$273.40	$343.06
Employee & 1 Child	$16.028	$1,335.66	$0	$616.46
Employee & Children	$19,488	$1,623.92	$0	$749.50
Employee & Spouse & Children	$19,488	$1,623.92	$0	$749.50
Employee & Domestic Partner & Children (non-dependent)	$19,488	$1,623.92	$133.05	$616.46

DENTAL PLANS & COSTS

DENTAL PLANS (OPTIONAL)	ANNUAL*	MONTHLY	BIWEEKLY (26 PAY PERIODS)	
			POST-TAX	PRE-TAX
CONCORDIA DHMO – Available to DCAA, Local 145, Local 911, POA, Unrepresented and Unclassified				
Employee only	$137	$11.37	$0	$5.25
Employee & Spouse	$273	$22.71	$0	$10.48
Employee & Domestic Partner (non-dependent)	$273	$22.71	$5.23	$5.25
Employee & Children	$239	$19.88	$0	$9.18
Employee & Spouse & Children	$423	$35.22	$0	$16.26
Employee & Domestic Partner & Children (non-dependent)	$423	$35.22	$7.08	$9.18
CONCORDIA DPO – Available to DCAA, Local 145, Local 911, POA, Unrepresented and Unclassified				
Employee only	$465	$38.72	$0	$17.87
Employee & Spouse	$929	$77.37	$0	$35.71
Employee & Domestic Partner (non-dependent)	$929	$77.37	$17.84	$17.87
Employee & Children	$906	$75.45	$0	$34.82
Employee & Spouse & Children	$1,435	$119.56	$0	$55.18
Employee & Domestic Partner & Children (non-dependent)	$1,435	$119.56	$20.36	$34.82
MEA METLIFE DHMO – Available to MEA Only				
Employee only	$240	$20.00	$0	$9.23
Employee & Spouse	$468	$38.94	$0	$17.97
Employee & Domestic Partner (non-dependent)	$468	$38.94	$8.74	$9.23
Employee & Children	$468	$38.94	$0	$17.97
Employee & Spouse & Children	$668	$55.66	$0	$25.69
Employee & Domestic Partner & Children (non-dependent)	$668	$55.66	$7.72	$17.97
MEA METLIFE DPPO – Available to MEA Only				
Employee only	$771	$64.18	$0	$29.62
Employee & Spouse	$1,443	$120.25	$0	$55.50
Employee & Domestic Partner (non-dependent)	$1,443	$120.25	$25.88	$29.62
Employee & Children	$1,664	$138.60	$0	$63.97
Employee & Spouse & Children	$2,422	$201.80	$0	$93.14
Employee & Domestic Partner & Children (non-dependent)	$2,422	$201.80	$29.17	$63.97
LOCAL 127 DENTAL HEALTH SERVICES DHMO – Available to Local 127 Only				
Employee only	$243	$20.20	$0	$9.32
Employee & Spouse	$428	$35.66	$0	$16.46
Employee & Domestic Partner (non-dependent)	$428	$35.66	$7.14	$9.32
Employee & 1 Child	$428	$35.66	$0	$16.46
Employee & Children	$599	$49.84	$0	$23.00
Employee & Spouse & Children	$599	$49.84	$0	$23.00
Employee & Domestic Partner & Children (non-dependent)	$599	$49.84	$6.54	$16.46
LOCAL 127 DENTAL HEALTH SERVICES DPO – Available to Local 127 Only				
Employee only	$474	39.46	$0	$18.21
Employee & Spouse	$919	$76.56	$0	$35.34
Employee & Domestic Partner (non-dependent)	$919	$76.56	$17.13	$18.21
Employee & 1 Child	$919	$76.56	$0	$35.34
Employee & Children	$1,718	$143.10	$0	$66.05
Employee & Spouse & Children	$1,718	$143.10	$0	$66.05
Employee & Domestic Partner & Children (non-dependent)	$1,718	$143.10	$30.71	$35.34

VISION PLANS & COSTS

VISION PLANS (OPTIONAL)	ANNUAL*	MONTHLY	BIWEEKLY (26 PAY PERIODS)	
			POST-TAX	PRE-TAX
COSD VSP – Available to DCAA, Local 127, Local 145, Local 911, POA, Unrepresented and Unclassified				
Employee only	$61	$5.05	$0	$2.33
Employee & Spouse	$122	$10.10	$0	$4.66
Employee & Domestic Partner (non-dependent)	$122	$10.10	$2.33	$2.33
Employee & Children	$130	$10.80	$0	$4.98
Employee & Spouse & Children	$208	$17.27	$0	$7.97
Employee & Domestic Partner & Children (non-dependent)	$208	$17.27	$2.99	$4.98
MEA VSP – Available to MEA Only				
Employee only	$194	$16.12	$0	$7.44
Employee & Spouse	$333	$27.69	$0	$12.78
Employee & Domestic Partner (non-dependent)	$333	$27.69	$5.34	$7.44
Employee & Children	$345	$28.73	$0	$13.26
Employee & Spouse & Children	$569	$47.41	$0	$21.88
Employee & Domestic Partner & Children (non-dependent)	$569	$47.41	$8.63	$13.25

LIFE INSURANCE PLANS & COSTS

LIFE INSURANCE PLAN (REQUIRED)	ANNUAL*	MONTHLY	BIWEEKLY (26 PAY PERIODS)
BASIC – Available to MEA, Local 127 & Local 911			
$10,000	$4	$0.30	$0.14
$25,000	$9	$0.75	$0.35
$50,000	$18	$1.50	$0.69
BASIC – Available to DCAA, Local 145, POA, Unrepresented & Unclassified			
$50,000	$0	$0	$0

PORTABLE TERM WITH AD&D LIFE INSURANCE: Newly benefited employees applying for Portable Term Life coverage within the first 30 days of eligibility may receive up to the Guaranteed Issue of $250,000 by enrolling through ESS>Benefits>Anytime Insurance.

Evidence of Insurability (EOI) is required for: a) level of coverage more than the "Guaranteed Issue" of $250,000; b) applying for more than one level allowed during open enrollment; c) applying for coverage for the first time and not a newly benefited employee; or c) lapse in paying the premium while on a leave of absence without pay. Coverage and payroll deductions will begin upon approval by The Hartford.

During open enrollment period, an employee currently enrolled for portable term life insurance with coverage level less than the Guaranteed Issue of $250,000, will be automatically approved to increase one level without providing Evidence of Insurability (EOI). The employee has to make the increase through ESS>Benefits>Anytime Insurance link on or before June 30.

NOTE: The Portable Term Life cost is based on Age. If your age changes to the next age bracket, the payroll system will automatically increase the cost of your portable term life insurance.

PORTABLE TERM LIFE – EMPLOYEE												
AGE	AMOUNT OF INSURANCE – BIWEEKLY (26 PAY PERIOD) DEDUCTION											
	$25,000	$50,000	$75,000	$100,000	$150,000	$200,000	$250,000	$300,000	$350,000	$400,000	$450,000	$500,000
<30	$0.53	$1.06	$1.59	$2.12	$3.18	$4.25	$5.31	$6.37	$7.43	$8.49	$9.55	$10.62
30 – 34	$0.76	$1.52	$2.28	$3.05	$4.57	$6.09	$7.62	$9.14	$10.66	$12.18	$13.71	$15.23
35 – 39	$0.88	$1.75	$2.63	$3.51	$5.26	$7.02	$8.77	$10.52	$12.28	$14.03	$15.78	$17.54
40 – 44	$1.11	$2.22	$3.32	$4.43	$6.65	$8.86	$11.08	$13.29	$15.51	$17.72	$19.94	$22.15
45 – 49	$1.57	$3.14	$4.71	$6.28	$9.42	$12.55	$15.69	$18.83	$21.97	$25.11	$28.25	$31.38
50 – 54	$2.61	$5.22	$7.82	$10.43	$15.65	$20.86	$26.08	$31.29	$36.51	$41.72	$46.94	$52.15
55 – 59	$4.68	$9.37	$14.05	$18.74	$28.11	$37.48	$46.85	$56.22	$65.58	$74.95	$84.32	$93.69
60 – 64	$7.22	$14.45	$21.67	$28.89	$43.34	$57.78	$72.23	$86.68	$101.12	$115.57	$130.02	$144.46
65 – 69	$14.03	$28.06	$42.09	$56.12	$84.18	$112.25	$140.31	$168.37	$196.43	$224.49	$252.55	$280.62
70 – 74	$23.72	$47.45	$71.17	$94.89	$142.34	$189.78	$237.23	$284.68	$332.12	$379.57	$427.02	$474.46
75 & Up	$23.72	$47.45	$71.17	$94.89	$142.34	$189.78	$237.23	$284.68	$332.12	$379.57	$427.02	$474.46

NOTE: Internal Revenue Code Section 79 requires that participants in this plan receive imputed income in instances where the plan rate is more favorable than the mortality rate used in IRC Section 79. Based on the cost of portable term life insurance this fiscal year, the imputed income does not apply. You will be notified if the Imputed income is added to your taxable wages through an adjustment to your W-2 form.

LIFE INSURANCE PLANS & COSTS

A newly benefited employee can enroll a spouse or domestic partner for the Guaranteed Issue of $50,000 portable term life insurance coverage without Evidence of Insurability within the first 30 days of employment or becoming eligible for benefits.

NOTES: When both employee and spouse/domestic partner are working for the City, only one (1) portable term life insurance coverage can be purchased per employee.

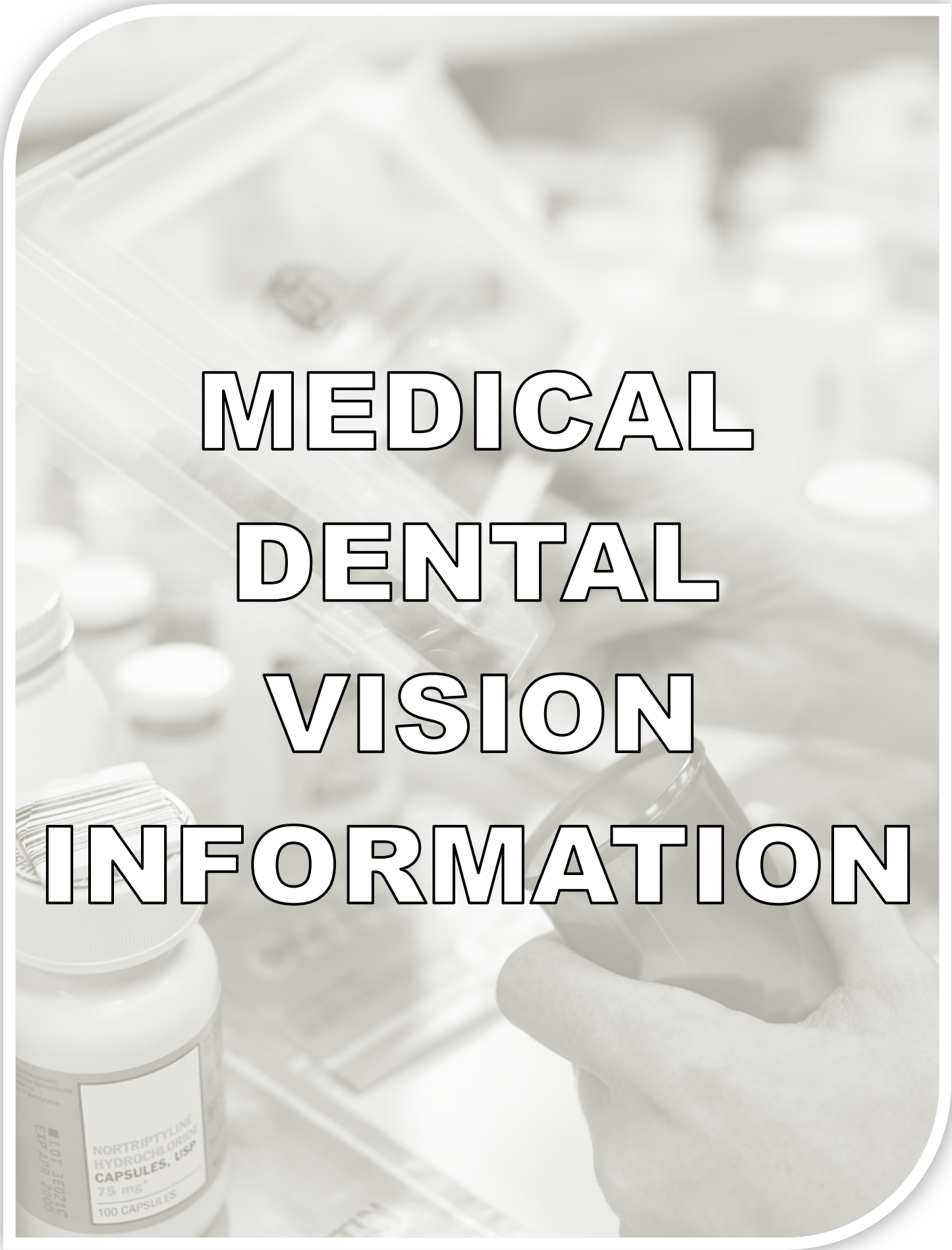
Remember: The combined portable term coverage for family or other dependents cannot be more than your Basic plus Portable coverage.

Your remittance of premium does not guarantee coverage for a dependent. If you pay premiums or contribute to the cost of coverage for an ineligible dependent, the insurance company may determine that benefits are not payable.

PORTABLE TERM LIFE – SPOUSE OR DOMESTIC PARTNER												
AGE	AMOUNT OF INSURANCE – BIWEEKLY (26 PAY PERIOD) DEDUCTION											
	$25,000	$50,000	$75,000	$100,000	$150,000	$200,000	$250,000	$300,000	$350,000	$400,000	$450,000	$500,000
<30	$0.58	$1.15	$1.73	$2.31	$3.46	$4.62	$5.77	$6.92	$8.08	$9.23	$10.38	$11.54
30 – 34	$0.81	$1.62	$2.42	$3.23	$4.85	$6.46	$8.08	$9.69	$11.31	$12.92	$14.54	$16.15
35 – 39	$0.92	$1.85	$2.77	$3.69	$5.54	$7.38	$9.23	$11.08	$12.92	$14.77	$16.62	$18.46
40 – 44	$1.15	$2.31	$3.46	$4.62	$6.92	$9.23	$11.54	$13.85	$16.15	$18.46	$20.77	$23.08
45 – 49	$1.62	$3.23	$4.85	$6.46	$9.69	$12.92	$16.15	$19.38	$22.62	$25.85	$29.08	$32.31
50 – 54	$2.65	$5.31	$7.96	$10.62	$15.92	$21.23	$26.54	$31.85	$37.15	$42.46	$47.77	$53.08
55 – 59	$4.73	$9.46	$14.19	$18.92	$28.38	$37.85	$47.31	$56.77	$66.23	$75.69	$85.15	$94.62
60 – 64	$7.27	$14.54	$21.81	$29.08	$43.62	$58.15	$72.69	$87.23	$101.77	$116.31	$130.85	$145.38
65 – 69	$14.08	$28.15	$42.23	$56.31	$84.46	$112.62	$140.77	$168.92	$197.08	$225.23	$253.38	$281.54
70 – 74	$23.77	$47.54	$71.31	$95.08	$142.62	$190.15	$237.69	$285.23	$332.77	$380.31	$427.85	$475.38
75 & Up	$23.77	$47.54	$71.31	$95.08	$142.62	$190.15	$237.69	$285.23	$332.77	$380.31	$427.85	$475.38

Portable Term Life Insurance coverage for children can be purchased if the employee or spouse/domestic partner is enrolled for Portable Term Life insurance. You can purchase children portable term life insurance within 30 days from the date your child was born or during the annual open enrollment period. Evidence of Insurability is not required to enroll dependent children.

PORTABLE TERM LIFE – CHILDREN	ANNUAL*	MONTHLY	BIWEEKLY (26 PAY PERIODS)
Coverage Amount Each Child			
$ 5,000	$12	$1.00	$0.46
$10,000	$15	$1.21	$0.56



MEDICAL
DENTAL
VISION
INFORMATION

MEDICAL PLANS AT A GLANCE

COVERED MEDICAL SERVICES	HEALTH NET HMO		KAISER
1. Type of Plan	A comprehensive Medical Maintenance Organization (HMO) serving California		A comprehensive group practice Medical Maintenance Organization (HMO)
2. Choice of Physician and Hospital	Must select a primary care physician within 52 Participating Medical Group (PMG). Each family member may pick their own PMG and primary care physician. Allowed to change physicians during the year. Call Membership services.		Services are provided by Kaiser Permanente Hospitals and Medical Offices throughout Southern California. Members select a personal physician from Kaiser Primary Care. Physician changes are made at member discretion. Self referral allowed for select medical specialties, all others require referral from primary care physician. Worldwide coverage is available for urgent and emergency care.
3. Deductibles/Maximums Plan Year Out-of-Pocket Maximum	No Deductible Individual - $1,500 Family - $3,000		No Deductible Individual - $1,500 – Calendar Year Family - $3,000 – Calendar Year
4. Maternity Prenatal visits Elective Abortion Lamaze Classes: Infertility Treatment	 Paid in Full Nursery/newborn charges covered from date of birth if newborn is enrolled in plan within 30 days of birth. $75 copayment Not covered 50% copayment (limitations apply) IVF, Artificial Insemination $500 + 80%* $2,000 lifetime maximum ZIFT not covered		 $5 copayment Delivery paid in full after $100 hospital copayment $15 copayment – Outpatient Covered for a Fee $15 copayment (does not count towards Out-of-Pocket maximum)
5. HOSPITAL Room (Semi-Private) Extras (Services & Supplies) Intensive Care Unit Extended Facility Care Outpatient Surgery	 $100 Co-payment per admission Paid in Full Paid in Full $100 Co-payment per admission $50 copayment		 $100 copayment per admission Paid in Full Paid in Full Paid in Full $50 copayment – Not done in hospital
HOSPITAL	MHN Network	Non-Network	
Psychiatric Care	$100 copayment per admission	Not Covered	$100 copayment per admission
Chemical Dependency Rehabilitation Inpatient	 $100 copayment per admission	 Not Covered	 $100 copayment per admission if prescribed-No limit $100 copayment for Residential Treatment
6. PHYSICIAN'S SERVICES Surgical Surgeon Assistant Surgeon Anesthesiologist	 Paid in Full Paid in Full Paid in Full		 Paid in Full Paid in Full Paid in Full
7. Physician Visits Office Visits Hospital Visits Chiropractor Well Baby	 $15 copayment Paid in Full $15 copayment - 40 visits combined with acupuncture Paid in Full		 $15 copayment Paid in Full $15 copayment - 40 visits $5 copayment
8. Psychiatric Care	MHN Network	Non-Network	$15 copayment per visit – Individual sessions
Outpatient	$15 copayment	Not Covered	$7 copayment per visit – Group sessions Up to 20 visits per calendar year.
9. Chemical Dependency (Drug & Alcohol) Outpatient	MHN Network $15 copayment	Non-Network Not Covered	$15 copayment per visit – Individual sessions $5 copayment per visit – Group sessions
10. Routine Check-Ups	Paid in Full		$15 copayment – Physical exams/school physicals Mammography

COVERED MEDICAL SERVICES	HEALTH NET HMO	KAISER
11.Prescription Drugs	Up to 30 days supply	Up to 30 days supply. Not subject to deductible.
Generic	$15 copayment	$15 copayment
Brand	$30 copayment	$30 copayment
Mail Order	Up to 90 days supply	Up to 100 days supply
Generic	$30 copayment	$30 copayment
Brand	$60 copayment	$60 copayment
Oral contraceptive & Norplant	Paid in Full	
Smoking Patches	50% copayment	
12. Registered Nurse	Paid in Full	Paid in Full
13. Allergy Treatment	Paid in Full – Test & Treatment Materials Included	Paid in Full
14. Physical Therapy	$15 copayment	$15 copayment
15. Hospice Care	Paid in Full	Paid in Full
16. Blood	Paid in Full	Paid in Full
17. X-Ray & Lab	Paid in Full	Paid in Full
18. Immunizations	$15 copayment	Paid in Full
19. Eye Examination		
Annual Vision Screening	Paid in Full	$15 copayment
Refractive exam	$15 copayment	
20. Ear Examination & Aids		
Annual Hearing Screening	Paid in Full	$15 copayment
Additional Exam	$15 copayment	$15 copayment
Hearing Aids	$500 max/not to exceed 2 devices every 36 months	$500 max/ear (every 36 months)
21. Emergency Care Coverage		Hospital copayment applies
Within the Service Area	$50 copayment (waived if admitted)	$50 copayment (waived if admitted)
Outside the Service Area*	$50 copayment (waived if admitted)	$50 copayment (waived if admitted)
22. Ambulance	Paid in Full	Paid in Full
23. Equipment Rental/Durable	(Such as wheelchairs, oxygen, iron lung & hospital bed)	Paid in Full
Medical Equipment	Paid in Full	
24. Prosthetics	(Such as artificial limbs & other corrective appliances)	Paid in Full
	Paid in Full	
25. Acupuncture	$15 copayment – 40 visits combined with chiropractic	Not Covered
26. Lifetime Benefit Maximum	Unlimited	Unlimited

* Represents amount payable when services are rendered by a Health Net (PPO) provider. Payment for services by a non-PPO provider is 60% of a limited fee schedule.

For more details, refer to the Health Net Evidence of Coverage booklet available through CityNet or contact Health Net at (800) 522-0088.

For more details, refer to the Kaiser Evidence of Coverage booklet available through CityNet or contact Kaiser at (800) 464-4000.

COVERED MEDICAL SERVICES	SHARP CLASSIC	SHARP SELECT
1. Type of Plan	A comprehensive Medical Maintenance Organization (HMO) serving San Diego & southern Riverside Counties.	A comprehensive Medical Maintenance Organization (HMO) serving San Diego & Southern Riverside Counties.
2. Choice of Physician and Hospital	Must select a participating Primary Care Physician (PCP). Each family member may pick their own PCP from over 800 primary care physicians & 1700 specialists in San Diego & southern Riverside Counties. These physicians practice through several major medical groups: Children's Physicians Medical Group, Sharp Rees Stealy with 17 locations in San Diego County, Sharp Community Medical Group, Primary Care Associates Medical Group & Greater Tri-Cities IPA. There are many providers and 10 Community Clinic sites where PCPs are also located. Allowed to change physicians during the year. Call Membership services.	Must select 900 Primary Care Physicians and Specialists. 20 locations.
3. Deductibles/Maximums Plan Year Out-of-Pocket Maximum	No Deductible Individual - $1,500 Family - $3,000	No Deductible Individual - $3,000 Family - $6,000
4. Maternity Prenatal visits Hospital Admission Elective Abortion Lamaze Classes: Infertility Treatment	 $15 copayment Nursery/newborn charges covered from date of birth if newborn is enrolled in plan within 30 days of birth. $100 copayment $150 copayment Discounted fees 50% copayment Artificial Insemination up to a lifetime maximum of three inseminations	 $0 copayment Nursery/newborn charges covered from date of birth if newborn is enrolled in plan within 30 days of birth. $150 copayment Discounted fees 50% copayment None
5. HOSPITAL Room (Semi-Private) Extras (Services & Supplies) Intensive Care Unit Extended Facility Care Outpatient Surgery	 $100 copayment per admission Paid in Full Paid in Full Paid in Full Paid in Full	 $750 copayment per admission Paid in Full Paid in Full Paid in Full $325 copayment
HOSPITAL Psychiatric Care Chemical Dependency Rehabilitation Inpatient	 $100 copayment per admission $100 copayment per admission	 $750 copayment $750 copayment
6. PHYSICIAN'S SERVICES Surgical Surgeon Assistant Surgeon Anesthesiologist	 Paid in Full Paid in Full Paid in Full	 Paid in Full Paid in Full Paid in Full
7. Physician Visits Office Visits Hospital Visits Chiropractor Well Baby	 $15 copayment Paid in Full $15 copayment - 40 visits combined with acupuncture Paid in Full	 $40 copayment Paid in Full Not Covered Paid in Full
8. Psychiatric Care Outpatient	 $15 copayment per visit – No visit maximum	 $40 copayment per visit – No visit maximum
9. Chemical Dependency (Drug & Alcohol) Outpatient	$15 copayment	$40 copayment
10. Routine Check-Ups	Paid in Full	Paid in Full

COVERED MEDICAL SERVICES	SHARP CLASSIC	SHARP SELECT
11.Prescription Drugs	Up to 30 days supply	Up to 30 days supply. Not subject to deductible.
Generic	$15 copayment	$20 copayment
Brand	$30 copayment	$35 copayment with $150 Deductible
Non-Formulary	$50 copayment	$70 copayment
Mail Order	Up to 90 days supply	
Generic	$30 copayment	$40 copayment
Brand	$60 copayment	$70 copayment with $150 deductible
12. Registered Nurse	Paid in Full – 100 visits per calendar year	$40 copayment – 100 visits per calendar year
13. Allergy Treatment	$15 copayment – Testing; $3 copayment - Injections	$40 copayment – Testing; $10 copayment - Injections
14. Physical Therapy	$15 copayment	$40 copayment
15. Hospice Care	Paid in Full	Paid in Full
16. Blood	Paid in Full	Paid in Full
17. X-Ray & Lab	Paid in Full	Paid in Full
18. Immunizations	Paid in Full; $15 copayment with Office Visit	Paid in Full; $40 copayment with Office Visit; Not Covered - Immunization for Travel
19. Eye Examination		
Annual Vision Screening	Paid in Full	Not Covered
Refractive exam	Discounted services – Use VSP Network	
20. Ear Examination & Aids		
Annual Hearing Screening	$15 copayment	$40 copayment
Additional Exam		
Hearing Aids	$1,000 every 3 years	Not Covered
21. Emergency Care Coverage		
Within the Service Area	$50 copayment (waived if admitted)	$100 copayment
Outside the Service Area*	$50 copayment (waived if admitted)	$100 copayment
22. Ambulance	Paid in Full	$100 copayment
23. Equipment Rental/Durable Medical Equipment	(Such as wheelchairs, oxygen, iron lung & hospital bed) Paid in Full	$2,000 Maximum payment per calendar year with 50% co-insurance
24. Prosthetics	(Such as artificial limbs & other corrective appliances) Paid in Full	Paid in Full
25. Acupuncture	$15 copayment – 40 visits combined with chiropractic	Not Covered
26. Lifetime Benefit Maximum	Unlimited	Unlimited

For more details, refer to the Sharp Evidence of Coverage booklet available through CityNet or contact Sharp at (888) 840-4747.

COVERED MEDICAL SERVICES	145 ANTHEM BLUE CROSS PREMIER HMO 20		POA ANTHEM BLUE CROSS CALIFORNIA CARE HMO	
1. Type of Plan	A comprehensive Medical Maintenance Organization (HMO) serving California.		A comprehensive Medical Maintenance Organization (HMO) serving California. Includes a comprehensive, Integrated VSP Vision Benefit Program.	
2. Choice of Physician and Hospital	Must select a Participating Medical Group (PMG) and then a physician within that group. There are 52 medical groups and over 1,000 primary care physicians in San Diego County. Each family member may pick their own medical group and primary care physician. You may also change physicians during the year. Call Membership services.		Must select a Primary Care Physician from the Anthem Blue Cross California Care Network. Each family member can choose his own primary care physician. You may change physicians during the year. Call Membership services.	
3. Deductibles/Maximums Plan Year Out-of-Pocket Maximum	No Deductible Individual - $1,500 Family - $3,000		No Deductible Individual - $500 Family - $1,500	
4. Maternity Prenatal visits Elective Abortion Lamaze Classes: Infertility Treatment	 $20 copayment $150 copayment Not covered Not Covered		 $5 copayment $150 copayment Not Covered 50% copayment for diagnosis & testing for infertility.	
5. HOSPITAL Room (Semi-Private) Extras (Services & Supplies) Intensive Care Unit Extended Facility Care Outpatient Surgery Emergency Room	 $200 Co-payment per admission $200 Co-payment per admission $200 Co-payment per admission Paid in Full $100 copayment $100 copayment (waived if admitted)		 Paid in Full Paid in Full Paid in Full Paid in Full - 100 days in a calendar year Paid in Full $25 copayment (waived if admitted)	
HOSPITAL Psychiatric Care Chemical Dependency Rehabilitation Inpatient	 Not Covered Not Covered Not Covered		The Holman Group Paid in Full Paid in Full	Non-Network Not Covered $25 copayment (Emergency)
6. PHYSICIAN'S SERVICES Surgical Surgeon Assistant Surgeon Anesthesiologist	 Paid in Full Paid in Full Paid in Full		 Paid in Full Paid in Full Paid in Full	
7. Physician Visits Office Visits Hospital Visits Chiropractor Well Baby	 $20 copayment Paid in Full $20 copayment Paid in Full		 $10 copayment Paid in Full $10 copayment – 20 visits per year $10 copayment per exam	
8. Psychiatric Care Outpatient	MHN Network $20 copayment per visit	Non-Network Not Covered	The Holman Group $10 copayment	Non-Network Not Covered
9. Chemical Dependency (Drug & Alcohol) Outpatient	MHN Network $20 copayment per visit	Non-Network Not Covered	The Holman Group $10 copayment	Non-Network Not Covered
10. Preventive Care Services	Paid in Full		$10 copayment per visit	
11. Prescription Drugs Generic Brand Non-Formulary Mail Order Generic Brand Non-Formulary Oral contraceptive & Norplant	Up to 30 days supply $15 copayment $30 copayment $50 copayment Up to 90 days supply $30 copayment $60 copayment $100 copayment		Up to 30 days supply. Not subject to deductible. $5 copayment $15 copayment Up to 90 days supply $5 copayment Covered	

COVERED MEDICAL SERVICES	145 ANTHEM BLUE CROSS PREMIER HMO 20	POA ANTHEM BLUE CROSS CALIFORNIA CARE HMO	
12. Registered Nurse	$20 copayment per visit	Paid in Full	
13. Allergy Treatment	$20 copayment per visit	$10 copayment	
14. Physical Therapy	$20 copayment per visit	$5 copayment per visit	
15. Hospice Care	Paid in Full	Paid in Full	
16. Blood	Paid in Full	Paid in Full	
17. X-Ray & Lab Advance Imaging	Paid in Full $100 copayment per test	Paid in Full	
18. Immunizations	Paid in Full	Paid in Full	
19. Eye Examination Annual Vision Screening	Paid in Full	Vision Coverage (See Below)	
20. Ear Examination & Aids Annual Hearing Screening Hearing Aids	Paid in Full Not Covered	$10 copayment Not Covered	
21. Emergency Care Coverage Within the Service Area Outside the Service Area*	$100 copayment (waived if admitted) $100 copayment (waived if admitted)	$25 copayment (waived if admitted) $25 copayment (waived if admitted)	
22. Ambulance	$100 per trip	Paid in Full	
23. Equipment Rental/Durable Medical Equipment	20% (Such as wheelchairs, oxygen, iron lung & hospital bed)	Paid in Full	
24. Prosthetics	Paid in Full (Such as artificial limbs & other corrective appliances)	Paid in Full	
25. Acupuncture	$20 copayment per visit	Not Covered	
26. Lifetime Benefit Maximum	Unlimited	Unlimited	
27. Integrated VSP Vision Plan	Not Covered	Vision Service Plan (VSP). Benefits through a VSP provider: Eye Exams: Paid in Full every 12 months; Lenses: Paid in Full every 24 Months Frames; or Contact Lenses: Up to $120 Allowance every 24 Months. 20% off any out-of-pocket costs for frames with a VSP Network Provider.	
28. Integrated Dental PPO Plan	Not Covered	POA ALADS Premier Plan - Medical Benefits Above Plus PPO Dental Plan Calendar Year Dental: $50/insured person; $150/family max. Annual Maximum: $1,500 per insured person.	
		In-Network	Out-of-Network
Diagnostic and Preventive Restorative/Endodontic Prosthodontics Orthodontics		No Copay/Deductible Waived 10% copayment 40% copayment 50% copayment $1,500 Ortho Lifetime Max.	No Copay/Deductible Waived 15% copayment 50% copayment 50% copayment

For more details, refer to the 145 Anthem Blue Cross Evidence of Coverage booklet available through CityNet or contact Local 145 at (619) 563-6161.

COVERED MEDICAL SERVICES	HEALTH NET PPO	
1. Type of Plan	A comprehensive Preferred Provider Organization (PPO) medical plan that allows the choice of providers.	
2. Choice of Physician and Hospital	May select any licensed physician or hospital. Physicians of Health Net's PPO Plan agree to accept payment made by Health Net as payment in full, subject to provisions of this Plan, such as deductible and coinsurance. There are over 5,000 contracting physicians within the San Diego County area.	
3. Deductibles/Maximums Plan Year Out-of-Pocket Maximum	$500 deductible. Three deductibles per family per plan year. Individual - $3,000/$6,000 Family – Three (3) deductibles	
4. Maternity Prenatal visits Elective Abortion Lamaze Classes: Infertility Treatment	 80%* 80%* Not covered $2,000 lifetime (IVF, Artificial Insemination, $500 + 80%* ZIFT not covered)	
5. HOSPITAL Room (Semi-Private) Extras (Services & Supplies) Intensive Care Unit Extended Facility Care Outpatient Surgery	 80%* 80%* 80%* 80%* 80%*	
HOSPITAL Psychiatric Care Chemical Dependency Rehabilitation Inpatient	PPO Network 80% 80%	Non-Network 60% 60%
6. PHYSICIAN'S SERVICES Surgical Surgeon Assistant Surgeon Anesthesiologist	 80% 80% 80%	
7. Physician Visits Office Visits Hospital Visits Chiropractor Well Baby	 $20 copayment 80%* $1,500 max $20 copayment Paid in Full	
8. Psychiatric Care Outpatient	PPO Network $20 copayment	Non-Network 60%
9. Chemical Dependency (Drug & Alcohol) Outpatient	PPO Network $20 copayment	Non-Network 60%
10. Routine Check-Ups	PPO Network Paid in Full	Non-Network Not Covered
11. Prescription Drugs Generic Brand Mail Order Generic Brand Oral contraceptive & Norplant Smoking Patches	Up to 30 days supply. Not subject to deductible. $15 copayment $30 copayment Up to 90 days supply $30 copayment $60 copayment Paid in Full Not Covered	
12. Registered Nurse	80%*	
13. Allergy Treatment	80%*	

COVERED MEDICAL SERVICES	HEALTH NET PPO
14. Physical Therapy	80%*
15. Hospice Care	80%*
16. Blood	80%*
17. X-Ray & Lab	80%*
18. Immunizations	Paid in Full
19. Eye Examination	
Annual Vision Screening	$20 copayment to age 16
Refractive exam	Paid in Full
20. Ear Examination & Aids	
Annual Hearing Screening	Paid in Full
Additional Exam	Covered for children only through age 16
Hearing Aids	Not Covered
21. Emergency Care Coverage	
Within the Service Area	80% after $100 Deductible (waived if admitted)
Outside the Service Area*	80% after $100 Deductible (waived if admitted)
22. Ambulance	$50 copayment + 80%
23. Equipment Rental/Durable	80%*
Medical Equipment	$5,000 maximum
24. Prosthetics	80%*
25. Acupuncture	80% Combined limit of $1,500 (PPO/OON)
26. Lifetime Benefit Maximum	Unlimited

* Represents amount payable when services are rendered by a Health Net (PPO) provider. Payment for services by a non-PPO provider is 60% of a limited fee schedule.

For more details, refer to the Health Net Evidence of Coverage booklet available through CityNet or contact Health Net at (800) 522-0088.

DENTAL PLANS AT A GLANCE

COVERED DENTAL SERVICES	CONCORDIA PLUS CA1321 DHMO	CONCORDIA PREFERRED DPO	
1. Type of Plan	A comprehensive Dental Health Maintenance Organization (DHMO) serving California.	A comprehensive Dental Preferred Organization (DPO). Its Network is Alliance.	
2. Choice of Dentist	Must select a Participating Dentist (PDO) from United Concordia's list of DHMO dentist. Your PDO will perform the procedures or refer You to a Specialty Care Dentist for further care. Treatment by an Out of Network Dentist is not covered, except as described in the Evidence of Coverage. Each family member can choose his own dentist and may change dentist during the year. Call Membership services.	Each family member can go to any licensed dentist of choice. Dental services can be obtained worldwide.	
3. Deductibles/Maximums		IN-NETWORK	OUT-OF-NETWORK
Plan Year Out-of-Pocket Maximum	No Deductible	No Deductible	$50 – Individual $150 – Family (excludes Preventive & Orthodontics)
Annual Maximum	No Annual Maximum limits	$1,500 per person (excludes Orthodontics)	$1,500 per person (excludes Orthodontics)
4. Preventive			
Exams	No Charge	100%	80%
X-rays	No Charge	100%	80%
Cleanings	No Charge	100%	80%
Fluoride	No Charge	100%	80%
5. AMALGAM RESTORATIONS	No Charge	80%	60%
6. CROWNS, BRIDGES, PARTIALS, DENTURES	Copayments as listed in the United Concordia Schedule of Benefits	50%	50%
7. ORTHODONTIA (BRACES)	$1,500 copayment for Children $2,000 copayment for Adults	$2,000 lifetime maximum per person	$2,000 lifetime maximum per person
8. IMPLANT SERVICES	Not Covered	Not Covered	Not Covered
9. REIMBURSEMENTS*	Not Covered	Alliance	90% of R & C

For more details, refer to the United Concordia Evidence of Coverage booklet available through CityNet or contact United Concordia at (866) 215-2359 for DHMO plan or (866) 215-2358 for DPO.

*Reimbursement is based on United Concordia's schedule of maximum allowable charges (MACs). Network dentists agree to accept our allowances as payment in full for covered services. If you or your family members receive services from a non-network provider, United Concordia will apply the percentage shown to the 90th percentile for covered services and you will be responsible for the difference, up to the provider's charge. United Concordia's standard limitations and exclusions apply.

COVERED DENTAL SERVICES	MEA METLIFE DHMO	MEA METLIFE DENTAL DPO	
1. Type of Plan	A comprehensive Dental Health Maintenance Organization (DHMO) serving California.	A comprehensive Dental Preferred Organization (DPO).	
2. Choice of Dentist	Must select a Participating Dentist (PDO) from MetLife's list of DHMO dentist. Your PDO will perform the procedures or refer You to a Specialty Care Dentist for further care. Treatment by an Out of Network Dentist is not covered, except as described in the Evidence of Coverage. Each family member can choose his own dentist and may change dentist during the year. Call Membership services.	Each family member can go to any licensed dentist of choice. Dental services can be obtained worldwide.	
3. Deductibles/Maximums		Negotiated IN-NETWORK	OUT-OF-NETWORK*
Plan Year	No Deductible	$50 per person (B&C)	$50 per person (B&C)
Out-of-Pocket Maximum			
Annual Maximum	No Annual Maximum limits	$1,750 per person	$1,750 per person
4. Preventive		PDP IN-NETWORK	OUT-OF-NETWORK*
Exams	No Charge	100% of Negotiated fee**	100% of R & C fee
X-rays	No Charge	100% of Negotiated fee**	100% of R & C fee
Cleanings	No Charge	100% of Negotiated fee**	100% of R & C fee
Fluoride	No Charge	100% of Negotiated fee**	100% of R & C fee
5. AMALGAM RESTORATIONS	No Charge	PDP IN-NETWORK	OUT-OF-NETWORK*
		90% of Negotiated fee**	80% of R & C fee
6. CROWNS, BRIDGES, PARTIALS, DENTURES	Copayments as listed in the MetLife Schedule of Benefits	PDP IN-NETWORK	OUT-OF-NETWORK*
		60% of Negotiated fee**	50% of R & C fee
7. ORTHODONTIA (BRACES)	$1,450 copayment for Children $1,450 copayment for Adults Refer to MetLife Schedule of Benefits	PDP IN-NETWORK 50% after deductible $1,500 Lifetime Maximum	OUT-OF-NETWORK* 50% after deductible $1,500 Lifetime Maximum
8. IMPLANT SERVICES	Copayments as listed in the MetLife Schedule of Benefits	PDP IN-NETWORK	OUT-OF-NETWORK*
		60% of Negotiated fee**	50% of R & C fee
9. REIMBURSEMENTS	Negotiated Fee Schedule	Negotiated Fee Schedule	90% of R & C

For more details, refer to the MetLife Dental Evidence of Coverage booklet available through CityNet or contact MEA at (888) 217-9175.

*Out of Network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary charge is based on the lowest of (1) the dentist's actual charge; (2) the dentist's usual charge for the same or similar services; or (3) the charge of most dentists in the same geographic for the same or similar services as determined by MetLife. Services must be necessary in terms of generally accepted dental standards.

** Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full, for services rendered by them. Negotiated fees are subject to change. Negotiated fees for non-covered services may not apply in all states.

Group dental insurance policies featuring the MetLife Preferred Dentist Program are underwritten by Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166.

COVERED DENTAL SERVICES	127 DENTAL HEALTH SERVICES DHMO	127 DENTAL HEALTH SERVICES DPO	
1. Type of Plan	A comprehensive Dental Health Maintenance Organization (DHMO) serving California.	A comprehensive Dental Preferred Organization (DPO	
2. Choice of Physician	Must select a Participating Dentist (PDO) from Dental Health Services' list of DHMO dentist. Your PDO will perform the procedures or refer You to a Specialty Care Dentist for further care. Treatment by an Out of Network Dentist is not covered, except as described in the Evidence of Coverage. Each family member can choose his own dentist and may change dentist during the year. Call Membership services.	Each family member can go to any licensed dentist of choice. Dental services can be obtained worldwide.	
3. Deductibles/Maximums Plan Year Out-of-Pocket Maximum Annual Maximum	 No Deductible No Annual Maximum limits	IN-NETWORK $50 – Individual (Major services) $150 – Family (Major services) $2,000 per person	OUT-OF-NETWORK $50 – Individual $150 – Family (excludes Preventive & Orthodontics) $2,000 per person
4. Preventive Exams X-rays Cleanings Fluoride	 No Charge No Charge No Charge No Charge	 100% 100% 100% 100%	 100% 100% 100% 100%
5. AMALGAM RESTORATIONS	No Charge	80%	80%
6. CROWNS, BRIDGES, PARTIALS, DENTURES	Copayments as listed in the Dental Health Services Schedule of Benefits	50%	50%
7. ORTHODONTIA (BRACES)	$1,350 copayment for 2 years of treatment	$1,775 lifetime maximum per Child-up to age 19 $1,975 lifetime maximum per Adult	
8. IMPLANT SERVICES	Discount plan included	Not Covered	Not Covered

For more details, refer to the Dental Health Services Evidence of Coverage booklet available through CityNet or contact Dental Health Services at (800) 637-6453.

VISION PLANS AT A GLANCE

COVERED VISION SERVICES	COSD VSP VISION	MEA VSP VISION
1. Type of Plan	A comprehensive Vision Preferred Organization (VPO).	A comprehensive Vision Preferred Organization (VPO).
2. Choice of Physician	You will receive quality eye wear and eye care services from VSP participating providers. VSP has the largest network of private practice eye care doctors in the industry. VSP doctors are located in retail, neighborhood, medical and professional settings. No ID card necessary or claim forms to complete when you see a VSP doctor.	You will receive quality eye wear and eye care services from VSP participating providers. VSP has the largest network of private practice eye care doctors in the industry. VSP doctors are located in retail, neighborhood, medical and professional settings. No ID card necessary or claim forms to complete when you see a VSP doctor.
4. **Eye Exam** Contact Lens	No Charge every 12 months Up to $60	No Charge every 12 months $60 copayment
5. Lenses	Combined with exam. No Charge every 12 months – Standard Single vision, lined bifocal & lined trifocal lenses Polycarbonate lenses for dependent children Photochromic lenses for dependent children	No Charge every 12 months Single vision, lined bifocal, lined trifocal, standard progressive lenses Polycarbonate lenses for dependent children
6. Frames	Combined with exam. No Charge every 24 months - $105 retail allowance; $125 for featured frame brands 20% off the amount over your allowance.	Every 12 months $150.00 allowance for frame of your choice 20% off the amount over your allowance.
7. Contact Lenses (Instead of Glasses)	$100 allowance for contacts; copay does not apply	$150 allowance for contacts
8. Lasik	15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities	Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.
9. Discount Vision Plan	Glasses and Sunglasses Extra $20 to spend on featured frame brands. Go to www.vsp.com/specialoffers for details 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last Well Vision Exam.	Average 20 – 25% savings on all non-covered lens options. 20% off additional glasses and sunglasses, including lens options, from the same VSP doctor within 12 months of your last Well Vision Exam.

For more details, refer to the COSD VSP Vision Evidence of Coverage booklet available through CityNet or contact VSP Vision at (800) 877-7195.

For more details, refer to the MEA VSP Evidence of Coverage booklet available through CityNet or contact San Diego Municipal Employees Association (MEA) at (888) 217-9175.

FSA DMV ELIGIBLE EXPENSES AND CONTACT INFORMATION

FSA DMV ALLOWABLE DENTAL, MEDICAL OR VISION EXPENSES

An employee can enroll for the FSA DMV with an annual contribution amount of $260 - $2,550 per calendar year. 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
Practitioner 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.

CONTACT INFORMATION

	WEBSITE OR EMAIL ADDRESS	PHONE #	GROUP #
FLEXIBLE BENEFITS PLAN	Benefits_Admin@sandiego.gov	1-619-236-5924	
EMPLOYEE GROUPS			
Local 127		1-619-640-4939	
Local 145		1-619-563-6161	
Municipal Employees Association	www.sdmea.org	1-888-217-9175	
Police Officers Association	www.mybenefitchoices.com/SDPOA sdpoa@bscinc.com	1-800-842-6635	
LIFE INSURANCE			
The Hartford	www.thehartford.com	1-888-563-1124	GL402711
HEALTH INSURANCE			
HealthNet	www.healthnet.com	1-800-522-0088	HMO-68765A PPO-N4696A
Kaiser	www.kaiserpermanente.org	1-800-464-4000	104303-04
Sharp	www.sharphealthplan.com	1-800-359-2002	79136
145 Anthem BC	http://www.anthem.com/ca	1-800-227-3670	278012
POA ALADS	www.mybenefitchoices.com/SDPOA	1-800-842-6635	57AJSA
DENTAL INSURANCE			
Concordia Plus DHMO	www.ucci.com	1-866-215-2358	836305001
Concordia Preferred DPO	www.ucci.com	1-800-947-6432	836305000
Local 127 Dental Health	www.dentalhealthservices.com/local127	1-800-637-6453	HMO-5024H PPO-5024P
MEA MetLife Dental	www.sdmea.org	1-888-217-9175	5343641
VISION INSURANCE			
COSD VSP Vision	https://www.vsp.com/go/cityofsandiego	1-800-877-7195	30057843/0001
MEA VSP Vision	www.sdmea.org	1-888-217-9175	No Group #
EMPLOYEE SAVINGS PLAN		1-619-236-6600	
LONG-TERM DISABILITY		1-619-236-6100	
SD City Employees Retirement		1-619-525-3600	
Healthy Families		1-800-675-2229	