

EMPLOYEE BENEFITS GUIDE

POLICE OFFICERS ASSOCIATION (POA)

Effective January 1, 2016 – December 31, 2016

2016



City of Milpitas
CALIFORNIA



Important Notice: Read Carefully

This benefits guide briefly describes your benefit choices and your options to enroll. All benefits, and your eligibility for benefits, are subject to the terms and conditions of the benefit plans, including group insurance contracts. This guide is not intended to be a complete description of the benefit plans, and it is not a summary plan description or plan document. In the event of any conflict or discrepancy between this guide and the plan documents, the plan documents will govern. City of Milpitas reserves the right to modify or terminate any of the described benefits at any time and for any reason. This guide is not a guarantee of current or future employment or benefits.

Welcome to Your Benefits Guide

Your benefits are a valuable addition to your overall compensation. Make sure you get the most from them by taking the time to understand your options and by selecting the best coverage for you and your family.

For information about the specific plans available to you, go online to <http://portal/mymilpitas>, or ask your HR Team.

This benefits guide describes your benefit choices and your options to enroll. Please be sure to read the Important Notice on the inside cover before you begin.

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A Message from the City

The City of Milpitas recognizes that to fulfill its mission, it requires a diverse group of highly qualified employees. The City also recognizes that the most important asset of the City's organization is the employees. To help ensure it will attract and retain the people needed to serve the citizens and community of Milpitas, the City maintains a comprehensive and competitive benefits program for its employees and their families.

Therefore, the City is committed to deliver an employee health benefits program that:

- Provides a "safety net" of basic benefits protection against the financial impact of catastrophic life events.
- Recognizes that benefits are an important element of total compensation from the City.
- Provides the highest quality and value of benefits at the most reasonable cost for both the City and its employees.
- Provides assistance for the provision of medical benefits upon retirement.
- The City's benefit program:
 - Reflects principles of sound financial management, fiscal responsibility, regulatory compliance and administrative efficiency at all times.
 - Is communicated effectively to promote full understanding of and the value represented by the benefits program.
 - Offers opportunities to enhance the basic benefits package, so that employees can address their particular benefits needs.

Employee Benefits Program

The City of Milpitas offers you and your eligible dependents the following benefits:

- Medical, Dental, and Vision insurance
- Basic Life and Voluntary Life
- Long-Term Disability (LTD) insurance (for employees only)
- Employee Assistance Program (EAP)
- Section 125
- Short Term Disability
- Deferred Compensation
- PERS Retirement
- Workers' Compensation

Enrollment

What You Need to Do

You will need to make choices about which benefits you'd like to participate in during "enrollment periods." Enrollment periods are specific times during which you are permitted to elect benefits coverage:

- When you become eligible to participate in benefits. You have 30 calendar days to enroll. See "What Happens If You Don't Enroll" in this guide for important information about not enrolling or declining coverage.
- During the annual Open Enrollment period. Any changes you make during the Open Enrollment period become effective the next plan year which starts – January 1, 2016.
- When you experience a qualified change in status event, such as marriage or the birth of a child or HIPAA special enrollment event. You must request enrollment due to these events within 30 calendar days of the event in order to make any election changes. See "Making Changes" in this guide for more details about when and how you may change your elections during the plan year.

Elections become effective first of the month following your date of hire or qualifying event.

Each time an enrollment period occurs, use this guide to familiarize yourself with the most current information on our benefit programs and what coverage options are available to you. You can also use this information to:

- Get ready to enroll
- Understand how to enroll
- Know what to expect after you enroll
- Learn what happens if you don't enroll

Get Ready to Enroll

1. Review your options, ask questions and talk with your family. If you're thinking of changing medical plans or you are choosing for the first time:
 - a. Check with your doctors to find out which plans they participate in.
 - b. If you take any prescription medications regularly, contact the new plan to find out how these drugs are covered (for example, formulary or nonformulary drugs)

Call the medical plan's Member Services number or visit its Web site (contact details are on page 21 of this guide).

- a. Consider not only your current circumstances but also what may occur in your life, in the future. Outside of the two-week Open Enrollment period, you will not be able to make changes to your benefits unless you have a qualified change in status event as explained in more detail under "Making Changes" in this guide.
2. Have the right information handy. When you start the enrollment process, you'll need:
 - a. Your Social Security number
 - b. The names, birth dates, and Social Security numbers of any dependents you wish to enroll, or of any beneficiaries you wish to designate

How to Enroll

Enrolling by Paper Form

Enrollment/Change forms are located online at <http://portal/mymilpitas> or call Human Resources at x 3090. HR will need the original enrollment/change forms and supporting documentation to verify that your dependents' are eligible for health benefits.

Cash In Lieu of Medical Coverage

Eligible employees may receive cash in lieu of medical coverage. If you waive medical, you will receive a \$125 per month reimbursement in your paycheck. Cash compensation is subject to all applicable income and employment taxes. Proof of other coverage along with a Medical Waiver Form must be provided on a yearly basis, and submitted to the City's HR Team.

What Happens if You Don't Enroll

If You Don't Enroll

If you are an active employee and you don't enroll in coverage for the next plan year during the Open Enrollment period, you will continue to receive your current medical, dental, vision and life insurance coverage for yourself and your covered dependents. You will not be automatically enrolled in any Flexible Spending Accounts (FSA) - you must elect coverage during Open Enrollment to participate in these plans in the next plan year.

You will not be able to make changes until the next annual Open Enrollment period or until you experience a qualified change in status event as defined by the City of Milpitas.

What Happens After Enrollment

ID Cards

After you enroll, you will receive ID cards from the medical plan you select. You will not receive an ID card for Dental and vision coverage.

When you receive your ID card, confirm that all information is accurate. If not, contact the plan right away.

Designating Health Care Providers

If you are required to designate a health care provider by the benefit plan, be sure to do so. Be sure to review your plan materials or the Web site to find out whether physician designation is required by your benefit plan.

Eligibility & Changes

Eligibility

If you're classified as a regular employee and you work 20 or more hours per week, you can participate in the benefits described in this guide. Coverage for employees begins on first of the month following date of hire.

Your Dependents

Your eligible dependents include:

- Your spouse (as defined by applicable state law)
- Your domestic partner who meets certain criteria (see below)
- Your children up to age 26 or older if disabled and incapable of self-support

Your children include:

- Your natural or adopted children (including children placed in your custody for adoption)
- Your stepchildren or the children of your domestic partner
- Your foster children or other children you support and for whom you are the legal guardian
- Children for whom you are required to provide coverage as the result of a qualified medical child support order (QMCSO).

You may be required to provide proof of eligibility for your dependents. Any falsification of this information is considered fraud or intentional misrepresentation and may result in disciplinary action, which could include termination of benefits and/or employment.

Domestic Partner Eligibility Criteria

Your eligible domestic partner includes a person who is a member of a domestic partnership or civil union legally established under applicable state law.

Making Changes

You can enroll in benefits as a new hire or during annual enrollment. Your coverage stays in effect for the entire plan year which goes from January 1st to December 31st. You cannot change your coverage, start or stop coverage, or add or drop any family members to or from your coverage, during the plan year unless you have a qualified change in status event as permitted under Internal Revenue Code and the City of Milpitas.

Qualified Change in Status Events

Examples of qualified change in status events include (but are not limited to):

- Change in marital or domestic partnership status (marriage or divorce, commencement or termination of domestic partnership)
- Change in number of dependents (birth, adoption or placement for adoption of a child; death of spouse or child)
- Change in eligibility (child loses eligibility due to age)
- Change in other coverage (you and/or your dependents gain or lose eligibility for coverage under another plan, such as your spouse's employer)

If you experience a qualified change in status event, you have 30 days to report the event and request an enrollment change that is consistent with the type of event. For instance, if the event is marriage, you may request an enrollment change to add your new spouse to your coverage. Enrollment changes due to qualified change in status events generally are effective the first of the month following the event, provided that you requested the enrollment change by the 30th day deadline. Coverage for a new child due to birth, adoption or placement of adoption generally is effective on the date of the event.

The plan's official documents govern how and when you can make enrollment changes during the plan year and may allow qualified change in status events in addition to those listed above. Your HR Team can provide complete details.

When you experience any type of family change, you should also consider updating your life insurance and beneficiaries at the same time. In addition, you may need to update your address or update your tax status by completing a new W-4 Form. For questions about tax forms or to update your address, contact the HR Team.

HIPAA Special Enrollment Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if you decline company-sponsored medical, dental or vision coverage for yourself or your dependents because you have other employer health insurance coverage (for example, through your spouse's employment), you may be able to enroll yourself and your dependents in the City's health care plan during the plan year if:

- You or your dependents lose eligibility for the other coverage
- The other employer stops contributing toward the other coverage
- You or your dependents lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage
- You or your dependents become eligible for a state's premium assistance program under Medicaid or CHIP

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in company benefits plans during the plan year.

For any HIPAA special enrollment event, you must request enrollment with 30 days after you or your dependent's other coverage ends (or after the other employer stops making a contribution toward the other coverage) or you acquire the new dependent. If the event is gaining or losing eligibility for coverage or premium assistance under Medicaid or CHIP, you have up to **60 days** to request a change.

For more information or to request special enrollment, contact the HR Team.

If You Leave Your Job

You and your dependents that are covered under your health benefits may have the right to continue participation as allowed under the Consolidated Omnibus Budget Reconciliation Act (commonly referred to as "COBRA") if coverage is lost due to certain events, such as termination of employment. COBRA generally allows you to continue coverage for a certain period of time by paying the monthly premiums yourself. Detailed information about your COBRA rights is provided when you join the Company or become eligible for health coverage. You may request another copy of your COBRA rights notice at any time. For more information, contact Custom Benefit Administrators and ask to speak to a COBRA representative.

You can convert life insurance coverage to an individual policy or port (take with you) your current term coverage within 30 days of your termination date.

Medical Plans

Your Medical Plans

You have the choice of several medical plans. For your specific plan options and costs, please refer to *the current CalPers Health Benefit Summary*.

- Anthem Blue Cross Select HMO
- Anthem Blue Cross Traditional HMO
- Blue Shield Access+ HMO
- Blue Shield NetValue HMO
- Kaiser Permanente HMO
- United Healthcare Alliance HMO
- PERS Select PPO
- PERS Choice PPO
- PERSCare PPO
- PORAC

Enrolling in an HMO?

Be sure to elect a primary care physician during annual enrollment!

What is an HMO and PPO?

HMO (Health Maintenance Organization): An organization that provides a wide range of comprehensive health care services through a designated group, or network of doctors, hospitals, labs and other providers. To receive benefits, you must see the doctor you select as your primary care physician first for care or a referral, except in the case of an emergency.

PPO (Preferred Provider Organization): Health care providers who are under contract to provide care at discounted or fixed fees. Unlike HMOs, health plans with a PPO allow you to choose any doctor at any time. However, if you select a non-PPO provider you will pay more out of pocket for services than you would if you selected a PPO "network" provider.

How to Choose the Best Plan for You and Your Family

When choosing a medical plan, it is important to look at your budget, your preferences and the age and health of you and your covered dependents. You should consider the key differences between plan types and choose one that best suits you and your family. The plans differ in the following areas:

- Cost of coverage, including payroll contributions and how you and the plan pay for services throughout the year
- Convenience, covered services, access to providers, ease of use

Medical — HMO Plans

Please note: This chart is just a brief overview of benefits and coverage for the medical plans. In the event information in this summary differs from the EOC, the EOC will prevail. You should also look at the detailed disclosure/summary documents for each plan, available from your HR Team or online at <http://portal/mymilpitas>. For questions about a specific procedure, service or provider, please contact the medical plan directly.

Benefits	Anthem Blue Cross Select HMO	Anthem Blue Cross Traditional HMO	Blue Shield Access+	Blue Shield Net Value	Kaiser	United Healthcare Alliance
Calendar Year Deductible (Single/Family)	N/A	N/A	N/A	N/A	N/A	N/A
Calendar Year Maximum (Single/Family)	\$1,500/\$3,000	\$1,500/\$3,000	\$1,500/\$3,000	\$1,500/\$3,000	\$1,500/\$3,000	\$1,500/\$3,000
Office Visits	\$15	\$15	\$15	\$15	\$15	\$15
Inpatient Hospitalization	No charge	No charge	No charge	No charge	No charge	No charge
Outpatient Facility/Surgery	No charge	No charge	No charge	No charge	\$15	No charge
Emergency Room Deductible	N/A	N/A	N/A	N/A	N/A	N/A
Emergency Room (copay waived if admitted)	\$50	\$50	\$50	\$50	\$50	\$50
Non-Emergency (copay waived if admitted)	\$50	\$50	\$50	\$50	\$50	\$50
Urgent Care Visits	\$15	\$15	\$15	\$15	\$15	\$15
Diagnostic X-Ray/Lab	No charge	No charge	No charge	No charge	No charge	No charge
Retail Pharmacy (up to a 30 day supply) ¹	\$5G / \$20B / \$50NF	\$5G / \$20B / \$50NF	\$5G / \$20B / \$50NF	\$5G / \$20B / \$50NF	\$5G / \$20B	\$5G / \$20B / \$50NF
Retail Pharmacy Maintenance Medications (up to a 30 day supply) ^{1,2}	\$10G / \$40B / \$100NF	\$10G / \$40B / \$100NF	\$10G / \$40B / \$100NF	\$10G / \$40B / \$100NF	N/A	\$10G / \$40B / \$100NF
Mail Order Pharmacy (up to a 90 day supply) ¹	\$10G / \$40B / \$100NF	\$10G / \$40B / \$100NF	\$10G / \$40B / \$100NF	\$10G / \$40B / \$100NF	\$10G / \$40B (31-100 day supply)	\$10G / \$40B / \$100NF
Maximum Prescription Out of Pocket (Single/Family)	\$5,350/\$10,700	\$5,350/\$10,700	\$5,350/\$10,700	\$5,350/\$10,700	\$5,350/\$10,700	\$5,350/\$10,700
Mail Order Calendar Year Prescription Copay Max (per person)	\$1,000	\$1,000	\$1,000	\$1,000	N/A	\$1,000

¹ G = Generic, B = Brand, NF = Non-Formulary

² Retail Pharmacy Maintenance Medications filled after 2nd fill (i.e. medication taken longer than 60 days)

Medical — PPO Plans

Please note: This chart is just a brief overview of benefits and coverage for the medical plans. In the event information in this summary differs from the EOC, the EOC will prevail. You should also look at the detailed disclosure/summary documents for each plan, available from your HR Team or online at <http://portal/mymilpitas>. For questions about a specific procedure, service or provider, please contact the medical plan directly.

Benefits	PERS Select		PERS Choice		PERS Care		PORAC	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Calendar Year Deductible (Single/Family)	\$500 / \$1,000		\$500 / \$1,000		\$500 / \$1,000		\$300 / \$900	\$600 / \$1,800
Calendar Year Maximum (Single/Family)	\$3,000 / \$6,000	N/A	\$3,000 / \$6,000	N/A	\$2,000 / \$4,000	N/A	\$3,300 / \$6,600	N/A
Office Visits	\$20	40%	\$20	40%	\$20	40%	\$20	10%
Inpatient Hospitalization	20%-30% (hospital tiers)	40%	20%	40%	\$250 + 10%	40%		10%
Outpatient Facility/Surgery	20%-30% (hospital tiers)	40%	20%	40%	10%	40%		10%
Emergency Room Deductible	\$50 (applies to hospital emergency room charges only)		\$50 (applies to hospital emergency room charges only)		\$50 (applies to hospital emergency room charges only)			N/A
Emergency Room (copay waived if admitted)	20% (applies to other services such as physician, x-ray, lab, etc.)	40%	20% (applies to other services such as physician, x-ray, lab, etc.)	40%	10% (applies to other services such as physician, x-ray, lab, etc.)	40%		10%
Non-Emergency (copay waived if admitted)	20% (payment for physician charges only; emergency room facility charge is not covered)	40%	20% (payment for physician charges only; emergency room facility charge is not covered)	40%	10% (payment for physician charges only; emergency room facility charge is not covered)	40%		50%
Urgent Care Visits	\$20	40%	\$20	40%	\$20	40%		10%
Diagnostic X-Ray/Lab	20%	40%	20%	40%	10%	40%		10%
Retail Pharmacy (up to a 30 day supply) ¹	\$5 G / \$20 P / \$50 NP		\$5 G / \$20 P / \$50 NP		\$5 G / \$20 P / \$50 NP (up to a 34-day supply)		\$10 G / \$25 P / \$45 NP	
Retail Pharmacy Maintenance Medications (up to a 30 day supply) ^{1,2}	\$10 G / \$40 P / \$100 NP		\$10 G / \$40 P / \$100 NP		\$10 G / \$40 P / \$100 NP (up to a 34-day supply)			N/A
Mail Order Pharmacy (up to a 90 day supply) ¹	\$10 G / \$40 P / \$100 NP		\$10 G / \$40 P / \$100 NP		\$10 G / \$40 P / \$100 NP		\$20 G / \$40 P / \$75 NP	N/A
Maximum Prescription Out of Pocket (Single/Family)	\$2,000 / \$4,000	N/A	\$2,000 / \$4,000	N/A	\$2,000 / \$4,000	N/A	\$2,000 / \$4,000	N/A
Mail Order Calendar Year Prescription Copay Max (per person)		\$1,000		\$1,000		\$1,000		N/A

¹ G = Generic, P = Preferred, NP = Non-Preferred

² Retail Pharmacy Maintenance Medications filled after 2nd fill (i.e. medication taken longer than 60 days)

Medical Premiums

2016			
Health Plan Provider	Coverage Level	TOTAL Monthly Premium	EMPLOYEE Monthly Premium
Anthem Blue Cross Select HMO	Single	\$721.79	\$0.00
	Single +1	\$1,443.58	\$0.00
	Family	\$1,876.65	\$0.00
Anthem Blue Cross Traditional HMO	Single	\$855.42	\$108.95
	Single +1	\$1,710.84	\$217.90
	Family	\$2,224.09	\$283.27
Blue Shield Access+	Single	\$1,016.18	\$269.71
	Single +1	\$2,032.36	\$539.42
	Family	\$2,642.07	\$701.25
Blue Shield Net Value	Single	\$1,033.86	\$287.39
	Single +1	\$2,067.72	\$574.78
	Family	\$2,688.04	\$747.22
Kaiser	Single	\$746.47	\$0.00
	Single +1	\$1,492.94	\$0.00
	Family	\$1,940.82	\$0.00
PERS Care	Single	\$889.27	\$142.80
	Single +1	\$1,778.54	\$285.60
	Family	\$2,312.10	\$371.28
PERS Choice	Single	\$798.36	\$51.89
	Single & 1	\$1,596.72	\$103.78
	Family	\$2,075.74	\$134.92
PERS Select	Single	\$730.07	\$0.00
	Single & 1	\$1,460.14	\$0.00
	Family	\$1,898.18	\$0.00
PORAC	Single	\$699.00	\$0.00
	Single & 1	\$1,399.00	\$0.00
	Family	\$1,789.00	\$0.00
UnitedHealthcare Alliance HMO	Single	\$955.44	\$208.97
	Single & 1	\$1,910.88	\$417.94
	Family	\$2,484.14	\$543.32

Dental Plan

Your Dental Plan

The City offers its employees dental benefits through Delta Dental of California, at no cost to you.

The Delta Dental PPO plan gives you the freedom to choose your own dentist and receive coverage from in-network and out-of-network providers. This plan is a preferred provider organization (PPO) made up of general dentists and specialists who have agreed to provide dental care at discounted fees. If you go to a dentist who participates in the PPO, you qualify for in-network coverage and benefit from discounted rates.

If you go to a dentist who is out of the network, you receive a lower plan benefit. Below is a quick summary of the key features and costs for both in-network and out-of-network services.

Benefit Highlights	Delta Dental
	In & Out-of-Network
Annual Deductible (Individual/Family)	\$25 Per Person
Waived for Preventative Services	Yes
Calendar Year Maximum	\$2,000 Per Person
Diagnostic & Preventative Services*	70% -100%
Basic Services*	70% -100%
Crowns & Cast Restorations	80%
Prosthodontics	70%
Orthodontia Services	50%
Orthodontia Lifetime Maximum	\$2,000 Per Person

The information presented in the chart is a summary only. The information does not include all of the detailed explanation of benefits, exclusions and limitations. Plan participants should refer to the Evidence of Coverage (EOC) document for coverage details. In the event information in this summary differs from the EOC, the EOC will prevail.

* Delta Dental will pay 70% of the Covered Fees for Diagnostic, Preventive, and Basic Benefits during the first calendar year of eligibility. This percentage increases 10% each consecutive year the dentist is visited to a maximum of 100%. If you do not use your plan, the percentage remains at the level you reached the previous year.

Vision Plan

Your Vision Plan

The City offers vision coverage through Medical Eye Services (MES), at no cost to you.

MES has the most extensive network of optometrists and vision care specialists in the country. Under this plan, you can use an MES provider or another provider of your choice. However, when you obtain vision care through a non-MES provider, you will receive a reduced level of benefits.

Here is a summary of covered services and costs:

Benefit Highlights	Medical Eye Services (via Blue Shield) Vision Basic 0/100	
	In Network Copayment	Out-of-Network Reimbursement
Examination		
Ophthalmologic	100%	\$60
Optometric	100%	\$50
Lenses		
Single Vision	100%	\$43
Bifocal	100%	\$60
Trifocal	100%	\$75
Aphakic Monofocal	100%	\$120
Aphakic Multifocal	100%	\$200
Polycarbonate (for covered dependent children)	Up to \$100	\$75
Frames	Up to \$120	\$40
Contact Lenses		
Medically Necessary		
Hard	100%	\$200
Soft	100%	\$250
Elective	Up to \$120	\$120
Service Frequency		
Examination	Every 12 Months	
Lenses	Every 12 Months	
Contact Lenses	Every 24 Months	
Frames	Every 24 Months	

Life Insurance

Basic Life and AD&D Insurance

Life insurance and Accidental Death and Dismemberment (AD&D) insurance provide funds for those who have lost someone or for those who are seriously injured. Life insurance pays funds to your designated beneficiaries after your death, while AD&D pays an amount equal to your life insurance benefit in the event of an accidental death or for certain accidental injuries. Basic life and AD&D is provided at no cost. As an eligible employee, you are provided with life and AD&D insurance equal to \$50,000.

Lincoln Financial Group – Life Insurance	
Benefits	
Life Insurance	\$50,000
AD&D Insurance	\$50,000
Conversion	Yes
Age Reductions	65% at age 70 45% at age 75 30% at age 80
Waiver of Premium	Totally disabled prior to Age 60; After 6-months waiting period
Accidental Death & Dismemberment (AD&D)	
Seat Belt Benefit	Lesser of 10% or \$10,000
Air Bag Benefit	Lesser of 10% or \$10,000
Repatriation	Included

AD&D Insurance

Meyers Stevens PORAC – AD&D Benefit Summary (Sworn Employees)

Benefit Highlights	PORAC AD&D
Losses Covered At the Principle Sum	<ul style="list-style-type: none"> • Loss of Life • Loss of Both Hands • Loss of Both Feet • Loss of Entire Sight or Both Eyes • Loss of One Hand and One Foot • Loss of One Hand and Entire Sight of One Eye • Loss of One Foot and Entire Sight of One Eye • Loss of Speech and Hearing (Both Ears) • Quadriplegia (total Paralysis of both upper body and lower limbs) • Paraplegia (total Paralysis of both lower limbs) • Hemiplegic (total Paralysis of upper and lower limbs on one side of the body) • Loss of Use of One Arm and One Leg • Loss of Use of Both Arms • Loss of Use of Both Legs
Losses Covered At One-Half the Principle Sum	<ul style="list-style-type: none"> • Loss of One Hand • Loss of One Foot • Loss if Entire Sight of One Eye • Loss of Speech • Loss of Hearing (Both Ears) • Loss of Use of One Arm • Loss of Use of One Leg • Loss of Thumb and Index Finger on the Same Hand
Covered Benefits	<ul style="list-style-type: none"> • Common Carrier • Common Accident • Special Education • Psychiatric/Psychological • Counseling Coma • Spouse Retaining • Child Care • Seat Belt Benefit

The information presented in the chart is a summary only. The information does not include all of the detailed explanation of benefits, exclusions and limitations. Plan participants should refer to the Evidence of Coverage (EOC) document for coverage details. In the event information in this summary differs from the EOC, the EOC will prevail.

For additional information regarding this benefit, please contact the HR Team.

Voluntary Life Insurance

In addition to the basic life insurance plan, you are eligible to purchase additional amounts of individual term life insurance for yourself, your spouse or your domestic partner, and your children.

- **Employee Benefit** – purchase up to a maximum of \$500,000 in increments of \$10,000 (not to exceed 5 times your salary)
- **Spouse/domestic Benefit** - up to \$250,000 in increments of \$5,000 (cannot exceed 50% of employee election)
- **Dependent child(ren) Benefit** – up to \$10,000 in increments of \$2,000

You must elect Voluntary Life insurance for yourself in order to make an election for any eligible dependents. Your spouse/domestic partner election cannot exceed 50% of your election.

There are three points to consider when deciding how much life insurance coverage you might need:

- If you have dependents that rely on you, how much will they need to pay off your current debts such as your mortgage, car loans, or credit card balances?
- What will it cost your dependents to maintain their current standard of living?
- What kind of future would you like to provide for your spouse, domestic partner or dependent children or others who rely on you for financial support?

Voluntary Life Insurance Monthly Premiums

Employee/Spouse Voluntary Life Insurance	
Under age 30	\$0.050
30-34	\$0.050
35-39	\$0.080
40-44	\$0.130
45-49	\$0.200
0-54	\$0.390
55-59	\$0.620
60-64	\$0.710
65-69	\$1.230
70-74	\$3.050
75 and older	\$11.980
Child or Children Voluntary Life Insurance	
\$2,000 Benefit	\$0.400
\$4,000 Benefit	\$0.800
\$6,000 Benefit	\$1.200
\$8,000 Benefit	\$1.600
\$10,000 Benefit	\$2.000

Please note:

1. Employee must purchase insurance for themselves, to purchase insurance for dependents.
2. Spouse benefits are based on the employee's age.
3. Child rates are per dependent unit, so the rate is the same for 1 or multiple children.
4. Rate changes due to age category changes take place on the policy anniversary, January 1st.
5. If this is not your initial eligibility period, you will need to complete the Evidence of Insurability (EOI) for Medical Underwriting. Lincoln may charge \$80 for the completion of the EOI/Medical underwriting process.

Naming Your Beneficiary

You may name anyone you wish as the beneficiary who will receive your life and AD&D benefits in case of your death. Once you have selected your beneficiary(ies), your designation will remain unchanged until you submit a new beneficiary designation form. You may change your beneficiary(ies) as often as you wish.

Long-Term Disability

Long-Term Disability (LTD) – Lincoln Financial Group (Non-Sworn Employee)

Long-term disability (LTD) insurance coverage helps protect you by replacing your income in the event you are unable to work due to a long-term illness or injury. The City offers a Core long-term disability plan and Buy-Up option through The Lincoln National Life Insurance Company.

Benefit Highlights	Lincoln Financial Group
Elimination Period	60-Days
Monthly Benefit Percentage	60% of Base Monthly Earnings
Maximum Monthly Benefit	
Core LTD	\$1,500
Buy-Up LTD ¹	\$6,000
Definition of Disability	24-Months; Own Occupation
Mental Health/Substance Abuse Limitations	24-Months
Survivor Income Benefit	3-Months
Maximum Benefit Duration	Later of Age 65 or SSNRA
Pre-Existing Condition Limitation	3-Months Prior/ 12-Months Insured
Waiver of Premium	Yes

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Please note: If this is not your initial eligibility period, you will need to complete the Evidence of Insurability (EOI) for Medical Underwriting. Lincoln may charge \$80 for the completion of the EOI/Medical Underwriting process.

Long-Term Disability (LTD) – CLEA (Sworn Employees)

Benefit Highlights	Milpitas POA
Percent of Wages Protected**	100% of Wages for Catastrophic Disabilities* for 18 months, then 80% (70% if IOD) 80% of Wages Non-Industrial Causes 70% of Wages Industrial Causes (No worker's Compensation permanent disability offsets)
Maximum Benefit	\$6,500 Per Month, Tax Free
Waiting Period	30 Days - If less than 60 days of personal leave, you may receive 50% of wages after 30 days. Otherwise, 60 calendar days.
Benefits Period	Lifetime coverage for Sickness, Accident, Pregnancy (Industrial Disability & Non-Industrial Disabilities)
Cost of Living (COLA)	4% compounded per year (Years 3-8); Thereafter, CPI increase to age 65 and then continued lifetime
Return to Work Incentive Benefit	\$1,000 Per Month for Non-Industrial Catastrophic Total Disability if a Member Returns to Gainful Employment
Waiver of Premium	After 60 Calendar Days and Receiving Benefits
Freeze of Personal Leave Option	After 60 Calendar Days
Personal Leave Integration Benefit	After 60 days: You may use 50% Personal Leave and receive a 50% Benefit from Plan or You may use 100% Personal Leave and receive \$1,000 Per Month
Benefits Payable During Challenged Worker's Compensation Cases	After 60 days: 70% of Wages to a Maximum Benefit of \$6,500 Per Month (Repayable only if settled in your favor)
Minimum Monthly Benefits	\$1,000 Per Month - Paid in Addition to Personal Leave After 60 Calendar Days (\$500 Per Month for Disputed Workers' Compensation Claims)
Disability Pension Advance	Plan May Advance, Interest Free, Actual Retirement Benefits Not to Exceed \$6,500 Per Month.
Survivorship Benefits	Six Months Addition Benefits to Dependent Beneficiary, Plus Death Benefit of \$55,000 - Suicide at \$10,000 (Benefits Maybe Payable Within 24 hours of Notification)
Death Benefit	Death benefit on or off duty natural, accidental or terminally ill, death benefit \$55,000 (\$10,000 initial benefit then \$1,500/Month for 30 Months) Suicide at \$10,000 (\$2,000 first 2 years in Plan) (Benefits Maybe Payable Within 24 hours of Notification)
Pre-Existing Medical Condition Coverage	If you enroll during your initial enrollment period, all pre-existing medical conditions will be covered once you have been in the plan for 24/48*** months, unless you are eligible for the Prior Coverage Credit - otherwise, pre-existing medical conditions will not be covered.
Ownership of Plan	Owned, and operated and managed by members through a Board of Directors (non-profit and non-political California Corporation since 1985)

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Flexible Spending Accounts

Flexible spending accounts (FSAs) help you save money on health care and dependent care expenses by paying for eligible expenses with tax-free dollars. **You must re-enroll in the accounts every year.**

Here's how you save:

- The amount you contribute to either or both FSAs is deducted from your paycheck before federal, state, local, and Social Security taxes are withheld
- When you have an eligible expense, you are reimbursed from your account(s) and the money isn't taxed

Important!

Estimate your expenses and make your contribution elections wisely. The balances in your Health Care and Dependent Care spending accounts are "use or lose." That is, you will lose any money that you don't use during the year.

Health Care Spending Account

You can use the Health Care Spending Account to pay for out-of-pocket health plan expenses including copays, coinsurance and deductibles. You can contribute up to \$2,550 each year.

Eligible expenses are "medically necessary" expenses not covered by your medical, dental or vision plans, including:

- Deductibles, copays and coinsurance
- Dental and orthodontia expenses
- Prescription glasses, contact lenses and lens cleaning solution
- Laser vision correction
- Prescription drugs and drug copayments
- Some over-the-counter medications, such as aspirin for pain or allergy medication

Eligible expenses do not include non-prescription drugs, cosmetic procedures, treatments not supervised by a qualified health care professional, and premiums for employer-provided health care plans, or expenses that are not considered medically necessary.

Please note: If you are enrolled in a Health Savings Account (HSA), you can only have a "limited purpose" health FSA that does not cover medical expenses.

Dependent Care Spending Account

You may use the Dependent Care Spending Account to pay for the day care of your dependent children under the age of 13, and dependents of any age who are incapable of self-care, live with you at least eight hours per day, and are claimed as dependents on your income tax return. You can contribute up to \$5,000 each year. However, if your spouse has access to a Dependent Care Spending Account, your total combined contribution may not exceed \$5,000. If you are married and file separate tax returns, each spouse may contribute \$2,500.

To be eligible, care must be provided while you (and your spouse, if you are married) work, look for work, or attend school full time. Eligible expenses include care in your home by an eligible provider or at a licensed facility. You will not be reimbursed for residential or "sleep-away" care, nursing home care, or for babysitting when you are not at work.

How to Pay for Eligible Expenses

You'll pay for your eligible out-of-pocket dependent care expenses using your personal credit card, cash or check. Then, submit a claim for reimbursement to Custom Benefit Administrators (CBA).

Deadline to Submit Claims for Reimbursement

You have until March 31, 2017 to submit claims for reimbursement from your Health Care and Dependent Care Spending Accounts. Reimbursement checks can be mailed to your home or deposited into your bank account if you sign up for direct deposit.

You may send your claims to CBA using any of the following methods:

- **E-MAIL** - E-mail claims to: customerservice@cbadministrators.com
- **FAX** - Local - (916) 303-7083 / Long Distance - (800) 584-4591
- **MAIL** - Mail to: CBA Claims Processing, P.O. Box 2170, Rocklin, CA 95677
- **Submit Online** - <http://www.sbadministrators.com> You will need to create a user ID and password.

Employee Assistance Program

The employee assistance program (EAP) offers you and your family information, referrals and short-term counseling for personal issues affecting work or personal life. Referrals are available for childcare services, legal consultations, older adult services and career management. No election is required for this benefit.

Employee Assistance Program	
Number of Visits	<p>Non-Sworn POA: 3 face to face visits per incident per member of household + up to 7 additional face to face visits per incident per member of household</p> <p>Sworn POA: 3 face to face visits per incident per member of household + up to 12 additional face to face visits per incident per member of household</p>
Telephone Number	(800) 242-6220
Website Information	www.members.mhn.com
	Company Code: milpitas
Services:	Your EAP can you help with:
Clinical Counseling	<ul style="list-style-type: none"> • Marriage, Family and Relationship Issues • Stress and Anxiety • Depression • Grief and Loss • Anger Management • Domestic Violence • Alcohol and Drug Dependency • Other Emotional Health Issues
Work & Life	<ul style="list-style-type: none"> • Childcare and Eldercare Assistance • Financial Services • Legal Services • Identity Theft Recovery Services • Daily Living Services
	Visit the MHN Member Website to:
Online	<ul style="list-style-type: none"> • Find an MHN Counselor and Get a Referral • Ask an Expert Questions Related to Emotional Health • Access Online Assessments and Self-Help Programs for Stress, Depression, Insomnia, Anxiety and Substance Abuse • Access Online Estate Planning Information and Tools • Use the Online Will-Making Program • Find Helpful Tips, Tools, and Articles

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457 Retirement Plan

The City of Milpitas offers you a 457 plan to help you save for your retirement. The best way to plan for retirement is to participate in a retirement savings vehicle, such as a 457 plan. The money you elect to put into your 457 plan will be deducted from your paycheck on a pre-tax basis. The IRS annual limit for contributions into your 457 in 2014 is \$17,500. If you are over age 50, the 2014 Catch-Up Contribution Limit is an additional \$5,500. The Pre-Retirement Catch-Up Contribution Limit is an additional \$17,500.

PERS Retirement	Refer to MOU for retirement plan details.
PERS Enhancements	Military Service Buy-back (GC 21024) PERS Credit for Unused Sick Leave (GC 20965) Death Benefit (GC 21620) Prior Service Credit (GC 20055) 1959 Survivor's Benefit – Level 3 (GC 21573)

Sworn Employees – In addition to the above PERS Enhancements, Sworn Employees have the following enhancements:

Disability Retirement 50% Maximum (GC21427)
Pre-Retirement Option 2 Death Benefit (GC21548)
1959 Survivor's Benefit – Level 4 (GC 21574)

ICMA-RC LOAN PROGRAM

Loans are available to active employees participating in the 457 deferred compensation plan, administered by ICMA-RC. Loans may be modeled and requested online or via an ICMA-RC Representative.

To Access the loan **application visit:** www.icmarc.org
Select **"Manage My Account"**
Select **"Loans"** OR Call ICMA directly at **1-800-669-7400**

Eligibility. Loans are available to active employees only.

Frequency. A loan may be requested once per year and you can only have one outstanding loan at a time.

Length of Loan. Loans must be repaid over a period that does not exceed 5 years.

Fees. A nonrefundable loan application fee is due when you apply for a new, refinanced or reamortized loan. Fees will be deducted from your account. A standard annual maintenance fee is deducted from your account (on the first day of the quarter containing the anniversary of the loan issuance) after each year the loan is outstanding. A processing fee will be assessed to your account when a scheduled loan repayment, via ACH, is rejected due to insufficient funds, invalid bank account information or account closure. Call ICMA directly for fee structure.

Loan Amount. The minimum permitted loan amount is \$1,000. The maximum loan amount is set by the Internal Revenue Code. The principal amount of the loan cannot exceed the lesser of: \$50,000, reduced by the highest outstanding loan balance during the previous 12 months or 50% of the value of your account, reduced by the highest outstanding loan balance during the previous 12 months.

Loan Repayment Process. Loan repayments will be made through direct debit from your bank account via Automatic Clearing House (ACH). You may pay the principal and interest obligation in full, earlier than the loan payoff date, without penalty or additional fee. Loan payments are made from after tax deductions.

Acceleration of Loan Repayments. **The outstanding loan balance is due and payable upon the employee's separation from service.**

Deemed Distribution of Delinquent Loan. The loan typically becomes a deemed distribution when payments are not made and will be treated as ordinary taxable income. The principal balance and accrued interest will be reported as a distribution to IRS, as a taxable event.

This is a summary of the loan feature. If there is any discrepancy between this information and the actual plan documents, the plan documents will govern.

Other Employee Benefits

Fitness / Sports Center Membership Benefit	The City of Milpitas recognizes the importance of physical fitness in contributing to the general good health and wellness of our employees. Although the group health insurance plans provide some discount for certain fitness facilities, The City of Milpitas provides the opportunity to participate in City-sponsored sports and fitness programs at no cost.	
Holidays	New Year's Day Martin Luther King, Jr.'s Birthday President Lincoln's Birthday President's Day Memorial Day Independence Day Labor Day Veteran's Day Thanksgiving Day Day after Thanksgiving Christmas Eve Christmas Day Floating Holiday	January 1 Third Monday in January February 12 Third Monday in February Last Monday in May July 4 First Monday in September November 11 Fourth Thursday in November Day after Thanksgiving Last working day prior to Christmas December 25 Must be used during the calendar year
Vacation	11 to 31 days per year, based on years of service Please refer to your MOU for details on accruals and use of leave.	
Sick Leave	Employees accrue 12 days per year. Please refer to your MOU for details.	
Additional Leaves	Please refer to your MOU for details on other types leaves, including: Military Leave, Compassionate Leave, Family Sick Leave, and Jury Duty	
Short Term Disability	Partial wage-replacement plan for non-industrial injuries/illnesses for up to one year. Employees must exhaust all accrued balances to qualify for Short Term Disability.	
Workers' Compensation	Non-Sworn Employees: 100% of regular pay for 2 calendar weeks (80 or 75 hours depending on work schedule) followed by 80% of regular pay for 6 calendar weeks (employees may supplement with accrued leave to achieve full salary). Sworn Employees: 100% of regular pay for 1 year per Labor Code 4850 Please contact your Human Resources Department with any questions.	
Tuition Reimbursement Program	The Tuition Reimbursement Program is designed to provide eligible employees with an opportunity to take approved job-related courses at an accredited institution. Please refer to your MOU for reimbursement amounts.	

Leave of Absence Policy

Please contact Human Resources if you have any questions regarding City of Milpitas's leave of absence policies.

Commuter Benefit Plan

The City of Milpitas offers to all full time permanent or temporary employees cash incentives or transit subsidy for employees who use a commute alternative at least 40% of the month. Commute alternatives include transit, carpool/vanpool, bicycling or walking to work. For additional information, please contact your HR Team.

Contacts

If you have questions you can contact the City’s HR Team, or the plan carriers. Use this chart to help guide you to the right resource on the first try.

Plan Carriers

PLAN	GROUP #	TELEPHONE #	WEBSITE
MEDICAL			
Anthem Blue Cross – PPO	n/a	877-737-7776	www.anthem.com/ca/calpers
Anthem Blue Cross – HMO	n/a	855-839-4524	www.anthem.com/ca/calpers/hmo
Blue Shield – HMO	n/a	800-334-5847	www.blueshieldca.com/calpers
Kaiser – HMO	n/a	800-464-4000	www.kp.org/calpers
UnitedHealthcare – HMO	n/a	877-359-3714	www.uhc.com/calpers
DENTAL			
Delta Dental	103	800-765-6003	www.deltadentalins.com
VISION			
MES Vision	F21998	800-877-6372	www.mesvision.com
FLEXIBLE SPENDING ACCOUNTS			
Custom Benefit Administrators	n/a	800-574-5448	www.cbadministrators.com
INCOME PROTECTION			
Lincoln Financial Group	n/a	800-423-2765	www.lfg.com
CLEA	n/a	800-832-7333	n/a
Meyers Stevens	n/a	800-827-4695	n/a
OTHER			
City of Milpitas	n/a	Phone: 408-586-3090 Fax: 408-586-3092	www.ci.milpitas.ca.gov

Glossary of Terms

AD&D (Accidental Death & Dismemberment)	A plan that provides benefits in the event of an accidental death or dismemberment (generally, an accident that results in death, loss of part of the body, or the loss of the use of part of the body).
Beneficiary	A person designated by a participant, or by the terms of an employee benefit plan, which is or may become entitled to a benefit under the plan.
COBRA	Federal law (Consolidated Omnibus Budget Reconciliation Act of 1985) requiring certain employers that offer group health plans to provide continuation coverage to employees and their dependents who incur certain qualifying events.
Co-Insurance or Cost Sharing	The portion of covered health care costs for which you are financially responsible. Coinsurance does not include deductibles or copays.
Co-Payment or Copay	A set amount you pay out of pocket for a particular service. The plan pays the balance.
Deductible	The out-of-pocket amount you must pay each plan year before the plan pays for eligible benefits.
Evidence of Insurability	Many insurance companies require prospective clients/ individuals to prove that they are in good health and are therefore good insurance risks before the company will cover them.
Explanation of Benefits (EOB)	A statement from a plan explaining what portion of a claim was paid.
Generic	Your prescription drug copay depends on the class or group of your prescribed medication. A generic drug generally has the lowest copay level. A generic drug is one that is no longer produced only under a brand name. Once a drug's patent expires, many companies can begin to manufacture "generic" versions of a previously brand-name-only drug. Generic drugs are identical to brand-name drugs in chemical makeup ("active ingredients"), usage, strength and dosage. They are regulated and approved by the FDA just like brand-name drugs; however, they are much less expensive.
HIPAA Authorization	Under HIPAA, a document that authorizes the use or disclosure of an individual's Protected Health Information as determined by the company.
In-Network Provider	A provider who has contracted with a health care plan (a medical, dental or vision plan) and agreed to certain rates. In most cases, you pay less and receive a higher benefit when you use in-network providers. Check with your plan for coverage details.
Negotiated rates	The costs for health care services negotiated between the insurance carrier and in-network health care providers. Negotiated rates are usually less than usual, customary and reasonable (UCR) charges.
Non-preferred brand	Your prescription drug copay depends on the class or group of your prescribed medication. A non-preferred brand-name drug generally has the highest copay level because it is not on the plan's list of preferred drugs. You can find out how different drugs are classified by your plan by visiting the plan's Web site.
Out-of-Pocket Expenses	Copays, deductibles, and other expenses that are not covered by the health plan.
Out-of-Network Provider	A state-licensed health care provider who has not contracted with a health care plan (medical, dental or vision plan) and has not agreed to certain rates. In most cases, you pay more and receive a lower level of benefits when you use out-of-network providers. See your plan for coverage details.
Qualified Change in Status	Certain events which may allow you to make allowable changes to your benefits. Qualifying events include: marriage, divorce, death, birth, adoption or placement for adoption, and significant change in employment.
Reasonable and Customary (R&C) or Usual, Reasonable & Customary (UCR)	A term used in many health plans, defined as the price at or below which the majority of health-care professionals of similar expertise charge for similar procedures within a specific geographic area.

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