



2020 Employee Benefits Guide



Small Town Service, Community Stewardship, Future Focus

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Town's Organizational Values



Town of Los Gatos

Mission

The Mission of the Town of Los Gatos is to enhance the quality of life in Los Gatos by providing the highest quality leadership and most efficient services and facilities. The Town strives to provide a working environment which promotes excellence; fosters cooperation; values volunteerism; and seeks to meet the needs of the community and the Town Council, employees, Commissions, Committees and Boards.

Customer Service Commitment

All Town employees consistently go the extra step to deliver highly competent and professional services in a respectful, effective, and transparent manner. We engage in open communication, relationship building, and problem solving to provide the best service possible.

Organizational Values

We are committed to serving the COMMUNITY of Los Gatos

- Small Town service – responsive, timely, courteous
- Cost-effective, quality services
- Seamless service delivery
- Public service orientation

We are committed to working together in COLLABORATION

- Open and constructive communication
- Collective goals and shared purposes

We are committed to valuing and pursuing CREATIVITY

- Innovation and creative problem solving
- Future orientation and proactive efforts
- Organization learning and continuous improvement
- Positive and enjoyable work environment

We are committed to approaching our work and each other with impeccable CHARACTER

- Ethics and integrity
- Honesty
- Trust and respect for one another
- Pride in work



A message from Town Manager, Laurel Prevetti



2020 Benefits Plan Year

Have questions?

Contact Human Resources:

Email: hr@losgatosca.gov

Telephone: (408) 399-5739

This benefits booklet is a summary only. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to your insurance company's Evidence of Coverage. The Evidence of Coverage is the binding document between the health plan and its members. If there are any discrepancies between the benefits in this booklet and the Evidence of Coverage, the Evidence of Coverage will prevail. You may also contact your insurance carrier with questions.

At the Town of Los Gatos, we recognize that the delivery of high quality services depends on our talented and dedicated workforce. We appreciate the contributions of each and every employee to make Los Gatos a special place. Thank you all!

Through our benefits programs, we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access, and affordable for all of our employees. Our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees for the Town. This brochure will help you choose the type of plan and level of coverage that is right for you.

Thank you for all you do every day and I am pleased to be able to offer you a range of employee benefits as part of your overall remuneration package.

Yours sincerely,

Town Manager
lprevetti@losgatosca.gov



2020 Benefits Highlights

These next two pages provide a high-level overview of the benefits available to you as a Town employee. Some are Town paid and some are voluntary, should you choose to participate.

Medical

Choosing the right health plan is probably one of the most important decisions you can make for you and your family. It is our objective to provide an employee benefit program with a high level of benefits making it easy for you and your dependents to access the medical care you need. Please carefully consider the plan information provided in this document to make the best medical choice for you and your family. Always remember to eat right and get plenty of exercise to feel your best!

The medical plans include prescription drug coverage. Generic drugs have the same active chemical ingredients and therapeutic effect as their brand-name equivalents, and are the least expensive.

The Town pays for 100% of the Kaiser plan for employee only coverage and 90% for dependent coverage.

Dental

Our dental plan makes dental care more affordable for employees and their families. Remember to choose a dentist contracted with our plan for the biggest dental benefit. Taking care of your mouth, teeth, and gums is a big part of making sure you feel your best. Healthy habits like brushing, flossing, and seeing your dentist for regular cleanings help prevent problems. The Town pays for the premiums for select dental plans.

Vision

Eye doctors detect problems in vision, overall eye health, and other health conditions like diabetic eye disease, high blood pressure, and high cholesterol. We know your eyesight is precious to you, so we provide vision benefits to make sure your trip to the eye doctor is reasonably priced. The Town pays for the premiums for vision (employee only).

Life and Accidental Death & Dismemberment (AD&D)

Life and Accidental Death & Dismemberment (AD&D) protects employees and their families from financial hardship in the event of death. It provides the peace of mind you get when you know your loved ones will be protected if anything happens to you. The Town provides employees with a \$50,000 policy at no cost to eligible employees. Employees may purchase additional insurance coverage for themselves and their eligible dependents at the start of each calendar year.

2020 Benefits Highlights *continued*

Disability

One of the most important assets to you as an employee is the ability to earn an income. The disability program is designed to continue providing you with income if you are unable to work due to sickness or injury. Disability insurance can help you continue to pay your bills by replacing a portion of your income until you are able to return to work. Short Term Disability premiums are paid by the Town. The benefit is 60% of weekly salary (max of \$1,300). Long Term Disability premiums are also paid by the Town. The benefit is 60% of monthly salary (max of \$6,000).

Employee Assistance Program

The Employee Assistance Plan (EAP) is an employer-paid benefit providing resources for everyday living. Employee assistance professionals provide counseling and referral for continued therapy or treatment services anytime you or a family member are seeking to maintain mental and emotional well-being. The EAP can assist with a variety of life's issues.

Flexible Spending Accounts

If you elect to participate in the Flexible Spending Accounts, you can set aside pre-tax dollars each year to cover your eligible out-of-pocket health-related expenses and/or daycare expenses.

Voluntary Plans

The Town also offers optional insurance plans including Term Life Insurance, Accident, Cancer, and Critical Illness coverage.

457 Deferred Compensation Plan

The Town offers an employee-funded 457 Deferred Compensation Plan to help employees build a path to financial wellness for retirement.

Retirement Benefits

For sworn (Safety) employees: CalPERS enrollment in either 3% at 50 benefit formula for Classic members or 2.7% at 57 benefit formula for New Members (PEPRA) dependent on the individual's eligibility.

For non-sworn (Miscellaneous) employees: CalPERS enrollment in either 2% at 60 benefit formula for Classic Members or 2% at 62 benefit formula for New Members (PEPRA) dependent on the individual's eligibility.

Tuition Reimbursement

\$1,500 per fiscal year for non-sworn employees; up to the cost of two semesters at San Jose State University per fiscal year for sworn employees.

Enrollment and Eligibility

If you decide to enroll in benefit coverage, whether it is during your initial eligibility as a new hire or during open enrollment, you must complete the enrollment process.

Eligibility

Who is eligible for benefits?

All regular Town of Los Gatos employees working at least 20 hours per week and more than 1,000 hours in a fiscal year may be eligible for benefits. If you are enrolling as a new employee, your medical, dental, and vision benefits are active as of the first of the month following the month in which you were hired, and your disability plan and life insurance is effective as of your date of hire. You may also choose to enroll your eligible dependents in many of our benefits. Contact the Human Resources department for specific plan details.

Who are eligible dependents?

Your eligible dependents include: your spouse (as defined by applicable state law); your domestic partner who meets certain criteria; your children up to age 26, including: biological and adopted children, stepchildren and domestic partner children; children for whom you are responsible to provide health coverage under a qualified medical child support order; economically dependent children as defined by CalPERS.

Enrollment and Qualifying Events

Each year you have the opportunity to make changes to your benefits package during open enrollment. With the exception of certain qualifying events, open enrollment is the only time benefit changes may be made. A qualifying event is a change in your personal life that may impact your eligibility or your dependent's eligibility for benefits. Examples of some qualifying events include: a change in legal marital status, change in number of dependents, change in employment status for you or your spouse, birth or adoption of a child. If such a change occurs, you must make the changes to your benefits within 30 days of the qualifying event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the qualifying event may result in your having to wait until the next open enrollment period to make your change. This includes the enrollment of a newborn child. Please contact Human Resources to make these changes.



Choosing a Medical Plan

Health Maintenance Organization (HMO)

A Health Maintenance Organization (HMO) plan provides health care from specific doctors and hospitals under contract with the plan, and you must select a Primary Care Physician (PCP) to coordinate your care. This type of plan has no deductible, and co-payments are due for services. Please note that the Anthem Select HMO plan has a smaller network of doctors.

Preferred Provider Organization (PPO)

A Preferred Provider Organization (PPO) plan allows you to obtain medical care from any provider, but you will receive a higher level of benefit and will have less out-of-pocket costs if you see a provider or go to a facility that is part of the network. This type of plan has an annual deductible that must be met first before most benefits apply. Please note that the PERS Select PPO has a smaller network of doctors.

Why would I choose a PPO Plan?

- You have a doctor that you like that you would like to keep seeing.
- You want to see specialists and other providers without having to obtain a referral and/or pre-approval first.
- You want the freedom to see providers who are not in the network.
- You are confident that you can manage your own care.

Why would I NOT choose a PPO Plan?

- You do not want the extra responsibility of managing your own care.
- You do not want to pay the higher premium costs and/or out-of-pocket costs when obtaining care.
- You do not want to receive bills from providers.

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 deductions and how you and the plan pay for services throughout the year.
- Convenience, covered services, access to providers, ease of use.

Contributions

Health Care Benefits

The Town provides a generous employer contribution toward the purchase of medical, dental, and vision coverage. When making a selection for a health plan, please note that the Town aligns its contribution rates with the CalPERS Kaiser Region 1 premium. The Town's Contribution Rates for the 2020 plan year are as follows:

Level of Participation	Medical	Dental	Vision
Employee Only	\$768.49	Up to \$124.80	\$10.64
Employee & 1 Dependent	\$1,460.14	Up to \$124.80	\$10.64
Employee & 2+ Dependents	\$1,875.11	Up to \$124.80	\$10.64

**Town Contribution Rates will be pro-rated for eligible employees based on part-time status.*

Cash In Lieu of Medical Coverage

Employees who have minimum essential medical coverage through other sources may elect to waive enrollment in the Town's medical plan. Those satisfying the Town's requirements may be eligible for a monthly cash in lieu payment amount. The employee must provide proof of other coverage in order to participate and proof of other coverage must be provided every plan year. The cash in lieu amounts are as follows:

Association Group	Monthly Amount
AFSCME	\$420.00
Confidential	\$800.00
Confidential (hired after 11/15/04)	\$400.00
Management	\$950.00
Management (hired after 11/15/04)	\$400.00
Police Officers' Association (POA)	\$922.00
Police Officers' Association (hired after 1/1/06)	\$400.00
Town Employee Association (TEA)	\$800.00
Town Employee Association (hired after 11/15/04)	\$400.00

Retiree Medical Benefit

The Town's Share of Retiree Medical Insurance for the 2020 plan year is as follows:

Level of Participation	Non-Medicare	Medicare Eligible
Employee Only	\$768.49	\$339.43
Employee & 1 Dependent	\$1,460.14	\$644.92
Employee & 2+ Dependents	\$1,747.16	\$950.40

Please Note: Employees hired after 7/1/18 (exact date dependent on bargaining unit or employee group) receive a maximum contribution of \$139 per month paid to CalPERS towards the purchase of retiree medical insurance.

Contributions *continued*

Cost of Coverage

Plan	Level of Participation	Premiums	Town Benefits	Out-of-Pocket Change (Amt) *	Total Monthly Deduction
MEDICAL – Region 1					
Health Maintenance Organization (HMO)					
Kaiser	Employee Only	\$768.49	\$768.49	\$0.00	\$0.00
	Employee & 1 Dep	\$1,536.98	\$1,460.14	\$0.02	\$76.84
	Employee & 2+ Deps	\$1,998.07	\$1,875.11	\$0.04	\$122.96
Anthem HMO Select	Employee Only	\$868.98	\$768.49	\$37.29	\$100.48
	Employee & 1 Dep	\$1,737.96	\$1,460.14	\$74.62	\$277.82
	Employee & 2+ Deps	\$2,259.35	\$1,875.11	\$97.03	\$384.24
Anthem HMO Traditional	Employee Only	\$1,184.84	\$768.49	\$73.46	\$416.34
	Employee & 1 Dep	\$2,369.68	\$1,460.14	\$146.96	\$909.54
	Employee & 2+ Deps	\$3,080.58	\$1,875.11	\$191.05	\$1,205.46
Blue Shield Access+ <i>Not available in Santa Clara county</i>	Employee Only	\$1,127.77	\$768.49	\$156.63	\$359.28
	Employee & 1 Dep	\$2,255.54	\$1,460.14	\$313.28	\$795.40
	Employee & 2+ Deps	\$2,932.20	\$1,875.11	\$407.27	\$1,057.08
Health Net SmartCare	Employee Only	\$1,000.52	\$768.49	\$98.72	\$232.02
	Employee & 1 Dep	\$2,001.04	\$1,460.14	\$197.48	\$540.90
	Employee & 2+ Deps	\$2,601.35	\$1,875.11	\$256.74	\$726.24
Preferred Provider Organization (PPO)					
PERSCare	Employee Only	\$1,133.14	\$768.49	\$1.21	\$364.64
	Employee & 1 Dep	\$2,266.28	\$1,460.14	\$2.46	\$806.14
	Employee & 2+ Deps	\$2,946.16	\$1,875.11	\$3.20	\$1,071.04
PERS Choice	Employee Only	\$861.18	\$768.49	-\$5.34	\$92.68
	Employee & 1 Dep	\$1,722.36	\$1,460.14	-\$10.64	\$262.22
	Employee & 2+ Deps	\$2,239.07	\$1,875.11	-\$13.81	\$363.96
PERS Select	Employee Only	\$520.29	\$768.49	\$0.00	\$0.00
	Employee & 1 Dep	\$1,040.58	\$1,460.14	\$0.00	\$0.00
	Employee & 2+ Deps	\$1,352.75	\$1,875.11	\$0.00	\$0.00
PORAC	Employee Only	\$774.00	\$768.49	-\$0.25	\$5.50
	Employee & 1 Dep	\$1,699.00	\$1,460.14	\$75.54	\$238.86
	Employee & 2+ Deps	\$2,199.00	\$1,875.11	\$122.42	\$323.88
DENTAL AND VISION					
Delta PPO	Employee Only	\$139.80	\$124.80	\$0.00	\$15.00
	Employee & 1 Dep	\$139.80	\$124.80	\$0.00	\$15.00
	Employee & 2+ Deps	\$139.80	\$124.80	\$0.00	\$15.00
DeltaCare HMO	All Tiers	\$44.66	\$44.66	\$0.00	\$0.00
Vision Service Plan (VSP)	Employee Only	\$10.64	\$10.64	\$0.00	\$0.00
	Employee & 1 Dep	\$15.25	\$10.64	\$0.00	\$4.61
	Employee & 2+ Deps	\$27.44	\$10.64	\$0.00	\$16.80

*Compared to 2019 out of pocket costs (employee share of premiums)

- PORAC is available to Public Safety/Sworn Employees only.
- Medical rates shown are based on the CalPERS 2020 Region 1.
- Not all HMO plans are available in all California counties. To check if these plans are available in your zip code, please visit the CalPERS website at <https://www.calpers.ca.gov/ghlt/zipsearch/memHealthPlanSearch.htm>.
- Enrollment can be based on residential or work zip code.
- Total monthly deduction is divided by two paychecks.



Retirement Benefits

The Town contracts with the Public Employees' Retirement System (PERS) to provide a defined pension benefit to eligible employees in the Safety and Miscellaneous groups in accordance with the California Public Employees' Pension Reform Act of 2012 (PEPRA). The benefits are as follows:

Safety – Tier 1 – Classic

Employees hired with reciprocity or CalPERS membership prior to 1/1/13 without a break in service of six months or more.

Retirement Formula	3% at 50
Final Average Compensation Period	1 Year
Employee Contribution	9%; 12% effective 10/6/19 pending amendment
Earliest Age of Retirement	50
Credit for Unused Sick Leave	Yes
1959 Survivor Benefits	Level 4 - \$500. Employee contributions \$.93 bi-weekly.

Safety – Tier 2 – PEPRA

Employees hired on or after 1/1/13 who are new members of the CalPERS system or had a break in service of six months or more.

Retirement Formula	2.7% at 57
Final Average Compensation Period	3 Years
Employee Contribution	12.75%
Earliest Age of Retirement	50
Credit for Unused Sick Leave	Yes
1959 Survivor Benefits	Level 4 - \$500. Employee contributions \$.93 bi-weekly.

Miscellaneous – Tier 1 – Classic

Employees hired at the Town and enrolled in CalPERS membership prior to 9/15/12.

Retirement Formula	2.5% at 55
Final Average Compensation Period	1 Year
Employee Contribution	8%
Earliest Age of Retirement	50
Credit for Unused Sick Leave	No
1959 Survivor Benefits	Level 4 - \$500. Employee contributions \$.93 bi-weekly.

Miscellaneous – Tier 2 – Classic

Employees hired on or after 9/15/12 with reciprocity or members of the CalPERS system prior to 1/1/13 without a break in service of six months or more.

Retirement Formula	2% at 60
Final Average Compensation Period	3 Years
Employee Contribution	7%
Earliest Age of Retirement	50
Credit for Unused Sick Leave	No
1959 Survivor Benefits	Level 4 - \$500. Employee contributions \$.93 bi-weekly.

Retirement Benefits *continued*

Miscellaneous – Tier 3 – PEPRA

Employees hired on or after 1/1/13 who are new members of the CalPERS system or had a break in service in the system for six months or more.

Retirement Formula	2% at 62
Final Average Compensation Period	3 Years
Employee Contribution	7.25%
Earliest Age of Retirement	50
Credit for Unused Sick Leave	No
1959 Survivor Benefits	Level 4 - \$500. Employee contributions \$.93 bi-weekly.

Council Members

Council Members are included in PERS classification of "Optional Membership". They may opt out of PERS membership for retirement when appointed, but may choose to enroll at any time in the future. They can enroll in a PERS health plan even if they elect to waive PERS membership. Council Members who enroll in PERS retirement will receive benefits at the appropriate miscellaneous Tier 1 Classic, Tier 2 Classic, or Tier 3 PEPRA, depending on the date of appointment to the Town Council.

Social Security and Medicare

The Town does not participate in Social Security, except for the required Medicare rate of 1.45% of all wages. Town employees contribute the applicable percentage of all wages toward Medicare. Rates and earnings limits are set by federal law.



my|CalPERS

Your resource for your personal account information

my|CalPERS is a personalized, centralized, and secure website that allows you to access your personal information quickly, easily, and reliably. You can use it to plan for your retirement, manage your health plans, and conduct your business with CalPERS. Access my|CalPERS at my.calpers.ca.gov.

How to Register for my|CalPERS

Not registered yet? Follow these steps:

- 1 On the Pre-Log In page, select **Participant** and **Continue**.
- 2 Select **Register now**.
- 3 **Accept** the terms and conditions under the security agreement.
- 4 Identify yourself by providing your name, date of birth, last four digits of your Social Security number, or your CalPERS Identification number.
- 5 Answer a set of questions about your CalPERS account to verify your identity.
- 6 Create a username and password, and enter your email address.
- 7 Choose a personal security image and message.
- 8 Choose your security questions and answers. It's important to choose questions and answers you will remember.
- 9 Log in to my|CalPERS.





Discover Your Options

CalPERS Health Open Enrollment 2019

Starts September 9 and ends October 4

2020 Health Program Highlights

Your Options

CalPERS offers seven Health Maintenance Organization (HMO) and three Preferred Provider Organization (PPO) options for Basic (non-Medicare) subscribers, including:

- Anthem Blue Cross
- Blue Shield of California
- Health Net
- Kaiser Permanente
- PERS Select/PERS Choice/PERSCare
- Sharp Health Plan
- UnitedHealthcare
- Western Health Advantage

CalPERS Medicare health plan options include:

- Anthem Medicare Preferred
- Kaiser Permanente Senior Advantage
- PERS Select/PERS Choice/PERSCare PPO Medicare Supplement Plans
- UnitedHealthcare Group Medicare Advantage PPO

Notable Health Premiums

CalPERS health plans will see an overall average premium increase of 4.65 percent in 2020.

Members enrolled in CalPERS' Basic (non-Medicare) Health Maintenance Organization (HMO) plans will see a 5.98 percent average premium increase. Members enrolled in Basic Preferred Provider Organization (PPO) plans will see an overall average increase of 3.28 percent. CalPERS Medicare plan enrollees will see their premiums increase by an average 1.52 percent.

Health care costs are rising due to a number of factors, including increases in hospital admissions, outpatient surgical procedures, and pharmacy costs.

The following graph represents the percentage premium change for each health plan, between 2019 and 2020. Note this reflects only the state Basic premiums, for comparison purposes only.

Visit the Health Benefits section of the CalPERS website at www.calpers.ca.gov to see the 2020 premiums for all health plans and their regions.

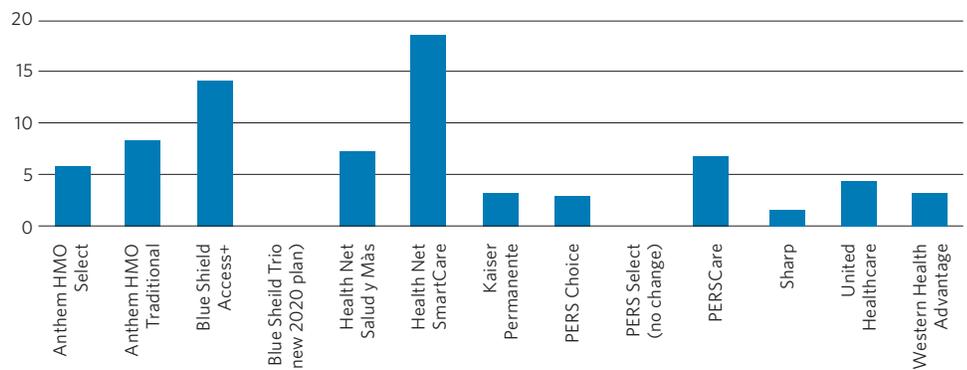


Head to my|CalPERS to view customized health benefit information. The Search Health Plans tool shows CalPERS health plans available in your area and whether your doctor accepts those plans.

my.calpers.ca.gov

2020 State Health Plan Premium Changes – Basic Rates

Percentage of Premium Change



2020 Health Plan Changes

Besides premiums, please review the following health plan changes for 2020:

- Blue Shield will introduce a new, narrow-network health plan called Trio for the following six counties: El Dorado, Los Angeles, Nevada, Placer, Sacramento, and Yolo.
- Anthem will introduce a new Medicare and combination plan for Monterey County. Contracting agency Medicare members enrolling in this plan may include dental and vision benefits for an additional fee.

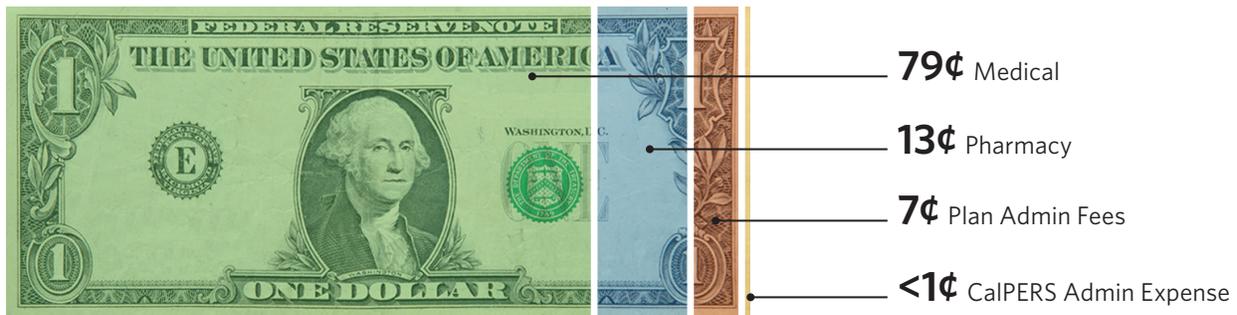
There are no co-pay, benefit, or co-insurance changes for 2020, with the exception of association plans which do not fall under CalPERS purview.

New premiums and health plan changes will take effect January 1, 2020.

Resources and Reminders

What Makes Up Your Health Premium

The Health Buck (below) shows that for every dollar of a health premium, medical costs make up 79 cents, pharmacy costs 13 cents, health plan administration fees 7 cents, and CalPERS administrative expense less than one cent. Federal law requires a minimum of 80 cents of every dollar to be spent on medical and pharmacy. CalPERS health plans spend 92 cents, far exceeding requirements. Still, we continue to decrease health care costs and partner with our plans to innovate solutions without sacrificing health care quality.



Important Health Enrollment Reminders

- Be aware that a medical group ending its contract with a health plan does not create a qualifying event to change plans outside of Open Enrollment.
- You will receive new health plan ID cards if you change your health plan or enroll for the first time.
- Carefully review your January 2020 pay warrant to ensure the health plan premium deduction was made when you change health plans, enroll for the first time, or add/delete dependents.
- If you change plans during Open Enrollment and you don't see the correct deduction applied by your February warrant, contact your employer's personnel specialist or health benefits officer in human resources (or CalPERS, if you are a retiree).
- If you change health plans, do not continue to use your previous health plan after December 31, 2019.

Additional Information for State and CSU Members

The Open Enrollment period for State of California and California State University (CSU)-sponsored dental and vision plans is also September 9 to October 4, 2019. Dental and vision programs are administered by the California Department of Human Resources (CalHR) for state employees, and by the Office of the Chancellor for CSU employees. For dental and vision contact information, visit the CalPERS website at www.calpers.ca.gov.



Open Enrollment Goes Mobile

Today, we live on our mobile phones. You can make important health decisions there, too. Access our mobile tool for customized Open Enrollment resources. Whether by phone or tablet, mobile.my.calpers.ca.gov helps you discover your options.

Health Plan Availability by County: Basic Plans

Some health plans are available only in certain counties and/or ZIP Codes. Use the chart below to determine if the health plan you are considering provides services where you reside or work. Contact the plan before enrolling to make sure they cover your ZIP Code and that their provider network is accepting new patients in your area. You may

also use our online service, the *Health Plan Search by ZIP Code*, available at www.calpers.ca.gov.

- Health plan covers all or part of county.
- ▲ Available out-of-state for PERS Choice and PERSCare, not available for PERS Select.
- Only applies to some agencies; does not apply to public agencies or schools.

County	Anthem Blue Cross EPO	Anthem Blue Cross Select HMO	Anthem Blue Cross Traditional HMO	Blue Shield Access+ HMO	Blue Shield Access+ EPO	Blue Shield Trio HMO	CAHP	CCPOA	Health Net Salud y Más	Health Net SmartCare	Kaiser Permanente	PERS Select, PERS Choice, & PERSCare	PORAC	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	Western Health Advantage HMO
Alameda		●	●				●	●		●	●	●	●		■	
Alpine							●					●	●			
Amador							●				●	●	●			
Butte			●	●			●	●				●	●			
Calaveras							●					●	●			
Colusa					●		●					●	●			●
Contra Costa		●	●				●	●		●	●	●	●		■	
Del Norte	●						●					●	●			
El Dorado		●	●	●		●	●	●			●	●	●			●
Fresno		●	●	●			●	●		●	●	●	●		●	
Glenn			●	●			●					●	●			
Humboldt			●	●			●					●	●			
Imperial		●	●	●			●	●				●	●			
Inyo							●					●	●			
Kern		●	●	●			●	●	●	●	●	●	●		●	
Kings			●	●			●	●		●	●	●	●		●	
Lake							●					●	●			
Lassen							●					●	●			
Los Angeles		●	●	●		●	●	●	●	●	●	●	●		●	
Madera			●	●			●	●			●	●	●		●	
Marin			●				●	●		●	●	●	●		■	●
Mariposa				●			●	●			●	●	●			
Mendocino			●		●		●					●	●			
Merced		●	●	●			●	●				●	●		■	
Modoc							●					●	●			
Mono							●					●	●			
Monterey		●					●					●	●			
Napa			●				●			●	●	●	●			●
Nevada		●	●	●		●	●	●				●	●			
Orange		●	●	●			●	●	●	●	●	●	●		●	

County	Anthem Blue Cross EPO	Anthem Blue Cross Select HMO	Anthem Blue Cross Traditional HMO	Blue Shield Access+ HMO	Blue Shield Access+ EPO	Blue Shield Trio HMO	CAHP	CCPOA	Health Net Salud y Más	Health Net SmartCare	Kaiser Permanente	PERS Select, PERS Choice, & PERSCare	PORAC	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	Western Health Advantage HMO
Placer		●	●	●		●	●	●			●	●	●		●	●
Plumas							●					●	●			
Riverside		●	●	●			●	●	●	●	●	●	●		●	
Sacramento		●	●	●		●	●	●			●	●	●		●	●
San Benito			●				●					●	●			
San Bernardino		●	●	●			●	●	●	●	●	●	●		●	
San Diego		●		●			●	●	●	●	●	●	●	●	●	
San Francisco		●	●				●	●		●	●	●	●		■	
San Joaquin		●	●	●			●	●		●	●	●	●		■	
San Luis Obispo			●	●			●	●				●	●		●	
San Mateo			●				●	●		●	●	●	●		■	
Santa Barbara			●	●			●	●				●	●			
Santa Clara		●	●				●	●		●	●	●	●		■	
Santa Cruz		●	●	●			●	●		●	●	●	●		■	
Shasta							●					●	●			
Sierra					●		●					●	●			
Siskiyou							●					●	●			
Solano			●				●	●		●	●	●	●		■	●
Sonoma			●				●	●		●	●	●	●		■	●
Stanislaus		●	●	●			●	●			●	●	●		■	
Sutter							●				●	●	●			
Tehama							●					●	●			
Trinity							●					●	●			
Tulare		●	●	●			●	●		●	●	●	●			
Tuolumne							●					●	●			
Ventura		●	●	●			●	●			●	●	●		●	
Yolo		●	●	●		●	●	●			●	●	●		●	●
Yuba							●				●	●	●			
Out-of-State											●	▲	●			

Tools to Help You Choose Your Health Plan

This section provides a variety of information that can help you evaluate your health plan choices. Included here are details about using your my|CalPERS account, the *Search Health Plans* tool, and the *Health Plan Choice Worksheet*.

Accessing Health Plan Information with my|CalPERS

You can use my|CalPERS at my.calpers.ca.gov, our secure, personalized website, to get one-stop access to all of your current health plan information, including details about which family members are enrolled. You can also use it to search for other health plans that are available in your area, compare health plans, access CalPERS Health Program

forms, and find additional information about CalPERS health plans. If you are a **retiree**, CalPERS is your Health Benefits Officer. Retirees may change their health plan during Open Enrollment by calling CalPERS toll free at **888 CalPERS** (or **888-225-7377**) or by using your my|CalPERS account.

my|CalPERS Health Plan Comparison Feature

Health Plan Resources

Choosing a health plan that's right for you is unique for every person or family. my|CalPERS includes additional resources to help you choose a health plan. These resources provide access to more detailed health benefit information that can help you when selecting what is most important to you in determining the plan that best fits your needs.

Evaluate Plan Features

Available health plans for you will be displayed based on the physical or mailing health eligibility ZIP Code in our system.

Create a customized plan search where you'll be able to review:

- Monthly premiums for each plan available to you
- Side-by-side comparisons of covered benefits, deductibles, and co-payments

Save Your Searches

Save as many as ten comparison scenarios with ability to review, rename, or delete at a later date.

Log in to your my|CalPERS account at my.calpers.ca.gov and select the "Health" tab and then select "Search Health Plans" to see what's available to you. To speak with someone at CalPERS about your health plan choices, call **888 CalPERS** (or **888-225-7377**).

Comparing Your Options: Search Health Plans

Access your my|CalPERS account for a convenient way to evaluate your health plan options and make a decision about which plan is best for you and your family. With this easy-to-use health plan comparison tool, you can weigh plan benefits and costs, and view how the plans compare.

You can access your account 24/7 to help you make health plan decisions at any time. You can use it to:

- Review health plan options during Open Enrollment.
- Evaluate your health plan options and estimate costs.
- Review a health plan option when your employer first begins offering the CalPERS Health Benefits Program.

- Review health plan options due to changes in your marital status or enrollment area.
- Explore health plan options because you are planning for retirement or have become Medicare eligible.

Be sure to tell us what you think about your my|CalPERS plan search experience by completing a survey at the end of your research.

Get customized assistance selecting the health plan that is right for you and your family by logging into your my|CalPERS account at my.calpers.ca.gov, selecting the “Health” tab and then selecting “Search Health Plans.”

Comparing Your Options: Health Plan Choice Worksheet

An alternative tool we provide to help you choose the best plan for yourself and your family is the *Health Plan Choice Worksheet*, which you can find on page 12 of this booklet. This worksheet can be used to compare factors such as cost, availability, benefits, and quality of care measures. Simply follow the steps listed in the left column of the

Worksheet. Several questions can be answered with a simple “yes” or “no,” while others will require you to insert information or call the health plan. Some of the information can be found on the CalPERS website at www.calpers.ca.gov. If you need assistance completing the form, contact CalPERS at **888 CalPERS** (or **888-225-7377**).

Health Plan Choice Worksheet

Plan name and phone numbers:								
Select the type of plan: <i>(circle choice)</i>	HMO	PPO	EPO	Assoc. Plan ¹	HMO	PPO	EPO	Assoc. Plan ¹
Step 1 — Cost								
Calculate your monthly cost. Enter the monthly premium (see current year's rate schedule). Premium amounts will vary based on 1-party/2-party/family and Basic/Medicare.								
Enter your employer's contribution. For contribution amounts, active members should contact their employer; retired members should contact CalPERS.								
Calculate your cost. Subtract your employer's contribution from the monthly premium. If the total is \$0 or less, your cost is \$0.								
Step 2 — Availability								
Search available plans online. Use our online service, the Health Plan Search by Zip Code, at www.calpers.ca.gov to find out if the plan is available in your residential or work ZIP Code. You may also call the plan's customer service center.								
Call the doctor's office. Confirm that they contract with the plan and are accepting new patients. Ask what specialists are available and the hospitals with which they are affiliated.								
Step 3 — Comparisons								
How does the plan rate in quality of care measures? See page 15 to find out.								
Compare the benefits. See pages 16–31. CalPERS plans offer a standard package of benefits, but there are some differences: acupuncture, chiropractic, etc.								
Step 4 — Other								
Other considerations: Does the plan offer health education? Do you or your family have special medical needs? What services are available when you travel? Are the provider locations convenient?								
What changes are you planning in the upcoming year (e.g., retirement, transfer, move, etc.)?								
Other information								
Compare and select a plan.								

¹ You must belong to the specific employee association and pay applicable dues to enroll in the Association Plans.

Additional Resources

As a health care consumer, you have access to many resources, services, and tools that can help you find the right health plan, doctor, medical group, and hospital for yourself and your family.

Health Plan Directory

Following is contact information for the health plans. Contact your health plan with questions about: ID cards; verification of provider participation; service area boundaries (covered ZIP Codes); benefits, deductibles, limitations, exclusions; and *Evidence of Coverage* booklets.

Anthem Blue Cross² HMO & EPO

(855) 839-4524

www.anthem.com/ca/calpers

Anthem Medicare Preferred² PPO

(855) 251-8825

www.anthem.com/ca/calpers

Blue Shield of California

(800) 334-5847

www.blueshieldca.com/calpers

California Association of Highway Patrolmen (CAHP)

(800) 734-2247

www.theca hp.org

California Correctional Peace Officers Association (CCPOA)

Medical Plan

(800) 257-6213

www.ccpoabtf.org

Health Net of California¹

(888) 926-4921

www.healthnet.com/calpers

Kaiser Permanente

(800) 464-4000

www.kp.org/calpers

OptumRx

Pharmacy Benefit Manager

Active Member Services

(855) 505-8110

Medicare Member Services

(855) 505-8106

www.optumrx.com/calpers

PERS Select² PERS Choice² PERSCare²

Administered by Anthem Blue Cross

(877) 737-7776

www.anthem.com/ca/calpers

Supplement to Medicare

(877) 737-7776

Peace Officers Research

Association of California (PORAC)

(800) 288-6928

<http://ibtoforac.org>

Sharp Health Plan¹

(855) 995-5004

www.sharphealthplan.com/calpers

UnitedHealthcare¹

Active Member Services

(877) 359-3714

Retiree Member Services

(888) 867-5581

www.uhc.com/calpers

Western Health Advantage¹

(888) 942-7377

www.westernhealth.com/calpers

¹ Pharmacy benefits administered by OptumRx for the Basic plan only.

² Pharmacy benefits administered by OptumRx for both Basic and Medicare plans.

Obtaining Health Care Quality Information

Following is a list of resources you can use to evaluate and select a doctor and hospital.

Hospitals

CalQualityCare

www.CalQualityCare.org

From hospitals to home care, CalQualityCare.org makes it easy to find providers and compare the quality of health care in California.

U.S. Department of Health and Human Services

www.medicare.gov/hospitalcompare

Hospital Compare has information about the quality of care at over 4,000 Medicare-certified hospitals across the country.

The Leapfrog Group

www.leapfroggroup.org

This is a coalition of health purchasers who have found that hospitals meeting certain standards have better care results.

Doctors and Medical Groups

Medical Board of California

www.mbc.ca.gov

This is the California State agency that licenses medical doctors, investigates complaints, disciplines those who violate the law, conducts physician evaluations, and facilitates rehabilitation where appropriate.

Have you done a checkup on your doctor's license?

The Medical Board of California encourages consumers to check up on their doctor's license. Such a checkup is simple and helps you make an informed choice when choosing a doctor. To determine a doctor's status, go to the Medical Board's website at www.mbc.ca.gov or if you do not have a computer, call (800) 633-2322 and Medical Board staff will look up the doctor for you.

Office of the Patient Advocate

www.opa.ca.gov

This website includes a State of California-sponsored "Report Card" that contains additional clinical and member experience data on HMOs, PPOs and medical groups in California.

Benefit Comparison Charts

The benefit comparison charts on pages 16–31 summarize the benefit information for each health plan. For more details, see each plan's *Evidence of Coverage* (EOC) booklet.

CalPERS Health Plan Benefit Comparison— Basic Plans

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

	EPO & HMO Basic Plans							
BENEFITS	Anthem Blue Cross	Blue Shield	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	CCPOA (Association Plan)	Western Health Advantage HMO
	EPO Select HMO Traditional HMO	Access+ HMO & Access+ EPO Trio HMO	Salud y Más & SmartCare					
Calendar Year Deductible								
Individual	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maximum Calendar Year Co-pay or Co-insurance (excluding pharmacy)								
Individual	\$1,500 (co-pay)	\$1,500 (co-pay)	\$1,500 (co-pay)	\$1,500 (co-pay)	\$1,500 (co-pay)	\$1,500 (co-pay)	\$1,500 (co-pay)	\$1,500 (co-pay)
Family	\$3,000 (co-pay)	\$3,000 (co-pay)	\$3,000 (co-pay)	\$3,000 (co-pay)	\$3,000 (co-pay)	\$3,000 (co-pay)	\$4,500 (co-pay)	\$3,000 (co-pay)
Hospital (including Mental Health and Substance Abuse)								
Deductible (per admission)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	\$100/admission	No Charge
Outpatient Facility/ Surgery Services	No Charge	No Charge	No Charge	\$15	No Charge	No Charge	\$50	No Charge

PPO Basic Plans										
BENEFITS	PERS Select		PERS Choice		PERSCare		CAHP (Association Plan)		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Calendar Year Deductible										
Individual	\$1,000 ¹ (not transferable between plans)		\$500 (not transferable between plans)		\$500 (not transferable between plans)		N/A		\$300	\$600
Family	\$2,000 ¹ (not transferable between plans)		\$1,000 (not transferable between plans)		\$1,000 (not transferable between plans)		N/A		\$900	\$1,800
Maximum Calendar Year Co-pay or Co-insurance (excluding pharmacy)										
Individual	\$3,000 (co-insurance)	N/A	\$3,000 (co-insurance)	N/A	\$2,000 (co-insurance)	N/A	\$3,000 (co-insurance)	N/A	\$2,000	N/A
Family	\$6,000 (co-insurance)	N/A	\$6,000 (co-insurance)	N/A	\$4,000 (co-insurance)	N/A	\$6,000 (co-insurance)	N/A	\$4,000	N/A
Hospital (including Mental Health and Substance Abuse)										
Deductible (per admission)	N/A		N/A		\$250		N/A		N/A	
Inpatient	20% ²	40%	20%	40%	10%	40%	10%	Varies	20%	
Outpatient Facility/ Surgery Services	20% ²	40%	20%	40%	10%	40%	10%	40%	20%	

¹ Incentives available to reduce individual deductible (max. \$500) or family deductible (max. \$1,000) include: getting a biometric screening (\$100 credit); receiving a flu shot (\$100 credit); getting a non-smoking certification (\$100 credit); getting a virtual second opinion (\$100 credit); and getting a condition care certification (\$100 credit).

² Coinsurance waived for deliveries if enrolled in Future Moms Program.

CalPERS Health Plan Benefit Comparison—Basic Plans, *Continued*

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

BENEFITS	EPO & HMO Basic Plans							
	Anthem Blue Cross	Blue Shield	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	CCPOA (Association Plan)	Western Health Advantage HMO
	EPO Select HMO Traditional HMO	Access+ HMO & Access+ EPO Trio HMO	Salud y Más & SmartCare					
Emergency Services								
Emergency Room Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	\$50	\$50	\$50	\$50	\$50	\$50	\$75	\$50
Non-Emergency (co-pay waived if admitted as an inpatient or for observation as an outpatient)	\$50	\$50	\$50	\$50	\$50	\$50	\$75	\$50
Physician Services (including Mental Health and Substance Abuse)								
Office Visits (co-pay for each service provided)	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Inpatient Visits	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Outpatient Visits	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Urgent Care Visits	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Preventive Services	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Surgery/Anesthesia	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostic X-Ray/Lab								
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

		PPO Basic Plans									
BENEFITS	PERS Select		PERS Choice		PERSCare		CAHP <i>(Association Plan)</i>		PORAC <i>(Association Plan)</i>		
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	
Emergency Services											
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)		\$50 (co-pay reduced to \$25 if admitted on an inpatient basis)		N/A		
Emergency	20% (applies to other services such as physician, x-ray, lab, etc.)		20% (applies to other services such as physician, x-ray, lab, etc.)		10% (applies to other services such as physician, x-ray, lab, etc.)		10% (applies to other services such as physician, x-ray, lab, etc.)		20%		
Non-Emergency	20%	40%	20%	40%	10%	40%	\$50+10%	\$50+40%	50% (for non-emergency services provided by hospital emergency room)		
Physician Services (including Mental Health and Substance Abuse)											
Office Visits (co-pay for each service provided)	\$35 ^{1,2}	40%	\$20 ²	40%	\$20 ²	40%	\$20	40%	\$10/\$35 ²	20%	
Inpatient Visits	20%	40%	20%	40%	10%	40%	10%	40%	20%	20%	
Outpatient Visits	\$20	40%	\$20	40%	\$20	40%	10%	40%	20%	20%	
Urgent Care Visits	\$35	40%	\$35	40%	\$35	40%	\$20	40%	\$35	20%	
Preventive Services	No Charge	40%	No Charge	40%	No Charge	40%	No Charge	40%	No Charge		
Surgery/Anesthesia	20%	40%	20%	40%	10%	40%	10%	40%	20%	20%	
Diagnostic X-Ray/Lab											
	20%	40%	20%	40%	10%	40%	10%	40%	20%	20%	

¹ Reduced to \$10 if enrolled with personal doctor.

² \$35 for specialist visit.

CalPERS Health Plan Benefit Comparison—Basic Plans, *Continued*

For more details about the benefits provided by a specific plan, refer to that plan’s Evidence of Coverage (EOC) booklet.

EPO & HMO Basic Plans								
BENEFITS	Anthem Blue Cross	Blue Shield	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	CCPOA (Association Plan)	Western Health Advantage HMO
	EPO Select HMO Traditional HMO	Access+ HMO & Access+ EPO Trio HMO	Salud y Más & SmartCare					
Prescription Drugs								
Deductible	N/A	N/A	N/A	N/A	N/A	N/A	Tier 2, 3, and 4: \$50 (not to exceed \$150/family)	N/A
Retail Pharmacy (not to exceed 30-day supply)	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Generic: \$5 Brand: \$20	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Tier 1: \$10 Tier 2: \$25 Tier 3 and 4: \$50	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50
Retail Preferred Pharmacy Maintenance Medications	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	N/A	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Tier 1: \$10 Tier 2: \$25 Tier 3 and 4: \$50	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100
Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand: \$40 (31-100 day supply)	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Tier 1: \$20 Tier 2: \$50 Tier 3 and 4: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100
Mail order maximum co-payment per person per calendar year	\$1,000	\$1,000	\$1,000	N/A	\$1,000	\$1,000	N/A	\$1,000
Durable Medical Equipment								
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

PPO Basic Plans										
BENEFITS	PERS Select		PERS Choice		PERSCare		CAHP <i>(Association Plan)</i>		PORAC <i>(Association Plan)</i>	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Prescription Drugs										
Deductible	N/A		N/A		N/A		N/A		N/A	
Retail Pharmacy (not to exceed 30-day supply)	Generic: \$5 Preferred: \$20 Non-Preferred: \$50		Generic: \$5 Preferred: \$20 Non-Preferred: \$50		Generic: \$5 Preferred: \$20 Non-Preferred: \$50		Generic: \$5 Formulary: \$20 Non-Formulary: \$50		Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$45 Compound: \$45	
Retail Preferred Pharmacy Maintenance Medications	Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Formulary: \$40 Non-Formulary: \$100		N/A	
Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Formulary: \$40 Non-Formulary: \$100		Generic: \$20 Brand Formulary: \$40 Non- Formulary: \$75	N/A
Mail order maximum co-payment per person per calendar year	\$1,000		\$1,000		\$1,000		N/A		N/A	
Durable Medical Equipment										
	20%	40%	20%	40%	10%	40%				
	(pre-certification required for equipment)		(pre-certification required for equipment)		(pre-certification required for equipment \$1,000 or more)		10%	40%	20%	20%

CalPERS Health Plan Benefit Comparison—Basic Plans, *Continued*

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

		EPO & HMO Basic Plans						
BENEFITS	Anthem Blue Cross	Blue Shield	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	CCPOA <i>(Association Plan)</i>	Western Health Advantage HMO
	EPO Select HMO Traditional HMO	Access+ HMO & Access+ EPO Trio HMO	Salud y Más & SmartCare					
Infertility Testing/Treatment								
	50% of Covered Charges	50% of Allowed Charges	50% of Covered Charges					
Occupational / Physical / Speech Therapy								
Inpatient (hospital or skilled nursing facility)	No Charge	No Charge						
Outpatient (office and home visits)	\$15	\$15	\$15	\$15	\$15	\$15	No Charge	\$15
Diabetes Services								
Glucose monitors	No Charge	No Charge						
Self-management training	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Acupuncture								
	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	N/A	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)
Chiropractic								
	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	\$15 exam (up to 20 visits per calendar year) chiropractic appliances benefit: \$50	\$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)

BENEFITS		PPO Basic Plans									
		PERS Select		PERS Choice		PERSCare		CAHP (Association Plan)		PORAC (Association Plan)	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Infertility Testing/Treatment											
		Not Covered		Not Covered		Not Covered		Not Covered		50%	50%
Occupational / Physical / Speech Therapy											
Inpatient (hospital or skilled nursing facility)		No Charge		No Charge		No Charge		10%	40%	\$20; Speech therapy: 10%	20%
Outpatient (office and home visits)		20%	40%; Occupational therapy: 20%	20%	40%; Occupational therapy: 20%	10%	40%; Occupational therapy: 10%	10%	40%	\$20	20%
		(pre-certification required for more than 24 visits)		(pre-certification required for more than 24 visits)		(pre-certification required for more than 24 visits)		(pre-certification required for more than 24 visits)			
Diabetes Services											
Glucose monitors		Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies	
Self-management training		\$20	60%	\$20	60%	\$20	60%	\$20	60%	\$20	60%
Acupuncture											
		\$15/visit	40%	\$15/visit	40%	\$15/visit	40%	10%	40%	\$20 (10% for all other services)	20%
		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)			
Chiropractic											
		\$15/visit	40%	\$15/visit	40%	\$15/visit	40%	10%	40%	\$20/up to 20 visits	20%
		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)			

Choose Your Plan

Love your smile



Delta Dental PPOSM & DeltaCare[®] USA* Town of Los Gatos, PPO #09284, DCUSA #72012

Your company lets you choose between two dental plans from Delta Dental. Either way, you'll get reliable dentist networks, affordable preventive care and a healthy smile that you'll love to show. Your options are:

Delta Dental PPO¹

This preferred provider plan offers the convenience and flexibility of visiting any licensed dentist, anywhere. Covered services are paid based on a percentage — if, for example, fillings are covered at 80%, you pay the remaining 20%. Get the most plan value by choosing a Delta Dental PPO dentist. PPO network dentists complete claim forms for you and can help advise you on questions regarding your share of the payment.

DeltaCare USA

Under this HMO-type plan, you'll have your choice of skilled primary care dentists from the DeltaCare USA network. Select a primary care dentist, who will then coordinate any needed referrals to a specialist.² Covered services provided by your DeltaCare USA dentist have preset copayments (dollar amounts), which are listed in your plan booklet. There are no maximums or deductibles for covered services.³

*See the inside back page of this brochure for the underwriters and administrators of these plans in your state.

Newly covered?
Visit deltadentalins.com/welcome.

LEGAL NOTICES: Access federal and state legal notices related to your plan: deltadentalins.com/about/legal/index-enrollee.html

¹ In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

² In WY, you do not need to select a primary care dentist, but you must visit a network dentist to receive benefits. In the following states, you can maximize your savings when you visit a network dentist, although you may visit any licensed dentist and receive out-of-network coverage: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT. Refer to your plan booklet for details about your out-of-network benefits.

³ Refer to your plan booklet for more information about covered services, deductibles and maximums.



We keep you smiling*
deltadentalins.com/enrollees

Keep Smiling

Delta Dental PPO™



Save with PPO

Visit a dentist in the PPO¹ network to maximize your savings.² These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.³ Find a PPO dentist at deltadentalins.com.

Set up an online account

Get information about your plan anytime, anywhere by signing up for an online account at deltadentalins.com. This free service, available once your coverage kicks in, lets you check benefits and eligibility information, find a network dentist and more.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your

plan, they will need your information. Prefer to take a paper or electronic ID card with you? Simply log in to your account, where you can view or print your card with the click of a button.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim, and we'll handle the rest.

Understand transition of care

Did you start on a dental treatment plan before your PPO coverage kicked in? Generally, multi-stage procedures are only covered under your current plan if treatment began after your plan's effective date of coverage.⁴ You can find this date by logging in to your online account.

Newly covered?

Visit deltadentalins.com/welcome.

Save with a PPO dentist



¹ In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

² You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

³ You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

⁴ Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

LEGAL NOTICES: Access federal and state legal notices related to your plan at deltadentalins.com/about/legal/index-enrollee.html.

Plan Benefit Highlights for: Town of Los Gatos

Group No: 09284

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the month dependent turns age 26			
Deductibles Deductibles waived for Diagnostic & Preventive (D&P) and Orthodontics?	Delta Dental PPO dentists: \$25 per person / \$75 per family each calendar year			
	Non-Delta Dental PPO dentists: \$50 per person / \$150 per family each calendar year			
Maximums D & P counts toward maximum?	\$1,500 per person each calendar year			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100 %	100 %
Basic Services Fillings and sealants	90 %	80 %
Endodontics (root canals) Covered Under Basic Services	90 %	80 %
Periodontics (gum treatment) Covered Under Basic Services	90 %	80 %
Oral Surgery Covered Under Basic Services	90 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	60 %	50 %
Prosthodontics Bridges, dentures and implants	60 %	50 %
Orthodontic Benefits Adults and dependent children	50 %	50 %
Orthodontic Maximums	\$1,500 Lifetime	\$1,500 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Delta Dental Premier® contracted fees for Premier dentists and the program allowance for non-Delta Dental dentists.

Delta Dental of California 560 Mission St., Suite 1300 San Francisco, CA 94105	Customer Service 800-765-6003	Claims Address P.O. Box 997330 Sacramento, CA 95899-7330
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deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Keep Smiling

DeltaCare[®] USA

provided by

Delta Dental of California



Dental benefits made easy!

When you enroll in a DeltaCare USA¹ plan, you'll choose a primary care dentist from our network of carefully screened, private practice dentists. You must visit your primary care dentist to receive benefits.²

- No restrictions on pre-existing conditions (except work in progress)
- Access to specialty care and out-of-area emergency care

A partner in oral health

Your DeltaCare USA plan encourages regular dental care with an extensive list of covered services to help you stay healthy.

- Low or no copayments for services like cleanings and exams

Budget-friendly costs

With your DeltaCare USA plan, there are no surprises. You'll know your copayments, and your out-of-pocket costs are clearly defined before treatment begins.

- No deductibles or maximums³ for covered services
- Pay only your copayment (if any) at the time of treatment

Convenient services

We make it easy for you — there are no claim forms to complete, and no plan ID card is required to receive treatment.

- Access plan information online
- Change your primary care dentist by phone or online

LEGAL NOTICES: Access federal and state legal notices related to your plan: deltadentalins.com/about/legal/index-enrollee.html

¹ DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, MI, MN, NE, OR, RI, SC, WA, WI — Dentegra Insurance Company; DC, DE, FL, GA, KS, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania; VA — Delta Dental of Virginia. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

² Verify that the dentist is your selected DeltaCare USA primary care dentist before each appointment.

³ Plans with an Accidental Injury Rider have a \$1600 annual maximum for accidental injury. Consult your Evidence/Certificate of Coverage.



We keep you smiling[®]

deltadentalins.com/enrollees

FAQ + A

Answers to frequently asked questions about your DeltaCare[®] USA plan

GETTING STARTED

1. How do I enroll in a DeltaCare USA plan?

Simply complete the enrollment process as directed by your benefits administrator. Be sure to select a primary care network dentist for yourself or your dependents, and indicate this dentist and the name of your group when you enroll.

2. How do I get started using my DeltaCare USA plan?

Once we process your enrollment, we'll mail you welcome materials that will include:

- **The name, address and phone number of your selected primary care dentist:** Simply call the dental facility to make an appointment. **Important note:** In order to receive benefits under your plan, you must visit your primary care network dentist for all services. If you require treatment from a specialist, your primary care dentist will coordinate a referral for you. You can change your primary care dentist by contacting us.
- **Your Evidence/Certificate of Coverage (plan booklet):** This useful document provides a thorough description of how to use your benefits, including covered services, copayments and any limitations and exclusions of your plan.
- **An ID card:** This card is for your records only — you do not need to present it in order to receive treatment.

3. How long will it take to get an appointment with my primary care dentist?

Two to four weeks¹ is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time, you may need to wait longer. Most DeltaCare USA dentists are in private group practices, which generally offer greater appointment availability and extended office hours.

4. How much will my dental treatments cost? How do I pay?

With your DeltaCare USA plan, some services are covered at no cost, while others have a copayment (amount you pay) for certain services. To find out how much a treatment will cost, refer to the "Description of Benefits and Copayments" in this brochure for a list of covered services and copayments. It's a good idea to bring your Evidence/Certificate of Coverage to your appointment in case you need to discuss your copayment for a service with your dentist. If you have any questions about the charges for a service, please contact our Customer Service department. If you receive treatment that requires a copayment, simply pay the dental facility at the time of service.

CHOOSING A DENTIST

5. How do I select my primary care dentist?

When you enroll, you must select a primary care dentist from the DeltaCare USA network. To search for a dentist, use the "Find a Dentist" tool at deltadentalins.com and select DeltaCare USA as your network. If you do not select a dentist when you enroll, we will choose one for you.

6. Does everyone in my family have to choose the same primary care dentist?

No. Each family member can select his or her own primary care network dentist.

7. Can I change my primary care dentist?

Yes. You can request to change your primary care dentist at any time. Simply visit our website and log on to your Online Services account or call or write to Customer Service. Change requests received by the 21st of the month will become effective the first day of the following month.

¹ In TX, three weeks is a reasonable amount of time to wait for a routine, non-urgent appointment.

8. My dentist says she is a Delta Dental dentist, but she isn't listed in the DeltaCare USA directory. Can I still visit her for services?

No. You must visit your selected primary care network dentist to receive benefits under this plan. Delta Dental has many networks, and participation may vary — not all Delta Dental dentists are DeltaCare USA dentists.

9. What should I do if I need to see a specialist?

If you require specialty dental care — such as oral surgery, endodontics, periodontics or pediatric dentistry — contact your primary care dentist to request a referral. Specialty dental services not performed by your selected primary care dentist must be authorized by us. You are responsible for any applicable copayments.

GENERAL PLAN INFORMATION

10. If I'm traveling, is emergency treatment covered under my plan?

You and your eligible dependents have out-of-area coverage for dental emergencies when you are more than 35 miles² from your primary care dentist. Your out-of-area emergency benefit (typically limited to \$100 per enrollee³ every 12 months³) is for services to relieve pain until you can return to your primary care network dentist. Standard plan limitations, exclusions and copayments may apply.

² In TX, there is no limit on the number of miles or on the dollar amount per emergency.

³ Exceptions may apply. Refer to your Evidence/Certificate of Coverage.

⁴ In TX, there is no exception for work in progress for covered DeltaCare USA benefits.

11. Can I access my plan online?

Yes. Visit deltadentalins.com/enrollees to create a free, secure Online Services account. On our website, you can access your plan benefits and ID card, select (or change) your primary care dentist — and more.

12. Does my plan cover pre-existing conditions? What about treatments that are in progress?

Treatment for pre-existing conditions (except work in progress⁴), including missing or extracted teeth, is covered under your plan. Treatment in progress includes services such as preparations for crowns or root canals, or impressions for dentures. If you started treatment before your plan's effective date, you and your prior dental carrier are responsible for any costs. Some DeltaCare USA plans may cover in-progress orthodontic treatment.

13. What if I have additional questions about my plan?

Please contact us for additional support. Our Customer Service agents can answer benefits questions as well as help you change your primary care dentist or arrange for urgent care referrals. See the back page of this brochure for our contact information.

We make it easy for you!



Select a DeltaCare USA Dentist



Receive your welcome materials



Schedule an appointment



Receive dental care



Pay only your share to dentist

Your Vision Benefits Summary



Get access to the best in eye care and eyewear with TOWN OF LOS GATOS and VSP® Vision Care.

Using your VSP benefit is easy.

- **Create an account at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** The decision is yours to make—with the largest national network of private-practice doctors, it's easy to find the in-network doctor who's right for you. Visit vsp.com or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on vsp.com.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Best Eye Care

You'll get the highest level of care, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe, CALVIN KLEIN, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.¹ Visit vsp.com to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.² Prefer to shop online? Check out all of the brands at eyeconic.com®, VSP's preferred online eyewear store.

Plan Information

VSP Coverage Effective Date: 01/01/2019

VSP Provider Network: VSP Signature

TOWN OF LOS GATOS and VSP provide you with an affordable eyecare plan.

Visit vsp.com or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

1. Brands/Promotion subject to change.

2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

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Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	<ul style="list-style-type: none"> • Focuses on your eyes and overall wellness • Every 12 months 	\$20 for exam and glasses
Prescription Glasses		
Frame	<ul style="list-style-type: none"> • \$150 allowance for a wide selection of frames • \$170 allowance for featured frame brands • 20% savings on the amount over your allowance • Every 24 months 	Combined with exam
Lenses	<ul style="list-style-type: none"> • Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months 	Combined with exam
Lens Enhancements	<ul style="list-style-type: none"> • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements • Every 12 months 	\$0 \$80 - \$90 \$120 - \$160
Contacts (instead of glasses)	<ul style="list-style-type: none"> • \$130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months 	Up to \$60
Glasses and Sunglasses		
Extra Savings	<ul style="list-style-type: none"> • Extra \$20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam. 	
	Retinal Screening	<ul style="list-style-type: none"> • No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam
	Laser Vision Correction	<ul style="list-style-type: none"> • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor
Your Coverage with Out-of-Network Providers		
Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.		
VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.		

Give your members complete eye health coverage with the VSP Primary EyeCare Plan. This important plan goes beyond routine eyecare and provides additional coverage for medical and urgent eyecare services. Members can self-refer¹, visit their VSP provider as often as needed, and pay only a copay for services. Plus, they'll have the reassurance and convenience of visiting the same eyecare provider who knows their eyes best.



VSP Primary EyeCare Plan Summary

Specialty Eyecare Services

- The VSP Primary EyeCare Plan provides supplemental² coverage for non-surgical medical eye conditions³ including:
 - diagnosis and tests for vision loss
 - treatment for conditions such as pink eye
 - management of glaucoma and diabetic eye disease
 - retinal screening for eligible members with diabetes
- VSP providers may use ocular photography to identify abrasions, growths, or other eye abnormalities.
- VSP providers also provide follow-up medical eyecare, including any necessary referrals and consultations with the patient's primary care physician.

VSP Providers

- VSP providers are in retail, neighborhood, and professional settings, with 88% offering extended hours.
- Our providers average 21 years in practice, with 99% network retention, so our members benefit from long-term, consistent care.
- 100% of our providers are credentialed to NCQA standards.
- All VSP providers use Evidence-Based Eyecare[®], which includes best-practice medical guidelines, comprehensive eye exam standards, and coordination of care with the patient's primary care physician.

Get up to \$110 back

Members can save big with VSP exclusive mail-in rebates on eligible popular contact lens brands from Bausch + Lomb and CooperVision.

\$500 savings on LASIK

Members can save up to \$500 on LASIK at NVision Eye Centers and TLC Laser Eye Centers.

Save up to \$2,500

With Exclusive Member Extras, members can save more than \$2,500 with special offers and rebates through VSP and other leading industry partners.

Learn More

Visit vsp.com/specialoffers.

¹ Unless referral by a primary care physician is required by the health plan.

² The VSP Primary EyeCare Plan pays secondary to other medical eye insurance coverage.

³ The VSP Primary EyeCare Plan provides a standardized set of services that can be performed by optometrists in most states. Contact your VSP representative for more information regarding specific coverage.



Offered by Life Insurance Company of North America, a Cigna company

Employer-Paid TERM LIFE INSURANCE

SUMMARY OF BENEFITS

Prepared for: Town of Los Gatos

Term Life insurance can help protect your loved ones' financial health if you are no longer there to support them.

Who Is Eligible For Coverage?:

You: All active, Full-time Employees and Elected Officials of the Employer regularly working a minimum of 20 hours per week. You will be eligible for coverage immediately.

Available Coverage:

	Benefit Amount	Maximum	Guaranteed Issue Amount
Employee	\$50,000	\$50,000	\$50,000

Guaranteed Issue means that you may be able to purchase coverage without medical exams or health questions. See "Guaranteed Issue" below for more information.

Additional Features:

Continuation of Disability – If your active service ends due to disability, at age 60 or over, your life insurance coverage will continue while you are disabled. Benefits will remain in force until the earliest of: the date you are no longer disabled, the date the policy terminates, the date you are Disabled for 12 consecutive months, or the day after the last period for which premiums are paid. You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your Regular Occupation, or you are receiving disability benefits under your Employer's plan.

Extended Death Benefit with Waiver of Premium – The extended death benefit continues your coverage without payment of premium, before you're eligible to qualify for Waiver of Premium, if you are continuously Disabled for 6 months prior to age 60. "Disabled" means, because of injury or sickness, you are unable to perform all the material duties of your regular occupation, or you are receiving disability benefits under a program sponsored by your Employer. Regular Occupation means the occupation you routinely performed at the time your Disability began. We/the insurance company will consider the duties of your occupations as those that are normally performed in the general labor market in the national economy. If you qualify for this benefit and have insured your spouse or children, the insurance company will also extend their coverage if applicable.

Waiver of Premium – If you become Disabled prior to age 60, and you remain Disabled continuously for a 6 month period and thereafter, you won't need to pay premiums for your life insurance coverage, provided we/the Insurance Company determine(s) you are Disabled. "Disabled" for this coverage means, because of injury or sickness, you are unable to perform the material duties of your regular occupation, or are receiving disability benefits under a program sponsored by your employer, for the first 12 months after your Disability began. Thereafter, you must be unable to perform the material duties of any occupation that you are or may reasonably become qualified based on your education, training or experience. If you qualify for this coverage and have insured your spouse or children, the insurance company will also waive their premium if applicable.

Accelerated Death Benefit – Terminal Illness – if two unaffiliated doctors diagnose you as terminally ill while the coverage is active, with a life expectancy of 12 months or less, the benefit for Terminal Illness provides up to:

Employee: 50% of your Term Life Insurance coverage amount or \$250,000, whichever is less.

Conversion – To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends.

Important Definitions and Policy Provisions:

When Your Coverage Begins and Ends – Coverage becomes effective on the later of the program's effective date, the date you become eligible, the date your enrollment elections are received if applicable, or the date you authorize any necessary payroll deductions if applicable. Your coverage will not begin unless you are actively at work on the effective date. Dependent coverage, if applicable, will not begin for any spouse or child who on the effective date is an inpatient in a facility or is home confined and under the care of a physician. Coverage will end on the earliest of the date you are eligible for coverage under a plan intended to replace this coverage, you or your dependents if applicable, are no longer eligible, the group policy is no longer in force, or required premiums are not paid.

Benefit Reductions, Exclusions and Limitations:

Benefit Reduction Schedule - If you are still employed, your benefits will reduce to 67% at age 65 and 45% at age 70.

Limitations - The Accelerated Death Benefit is payable only once. Using this benefit reduces the life insurance death benefit. The amount payable under the Accelerated Death Benefit may be reduced by the amount of other benefits already paid to the insured under the policy. See your certificate for details. Benefits will be extended without premium payment until the earlier of the date you are no longer disabled, or the date you fail to qualify for Waiver of Premium or fail to provide proof of Disability. **Waiver of Premium** – After premiums have been waived for 12 months, they will be waived for future periods of 12 months if you remain Disabled. This benefit will remain active until age 65 subject to proof of continuing disability each year.

Guaranteed Issue:

If you are a new hire and you apply within 31 days after you are eligible to elect coverage for yourself, you are entitled to choose any coverage offered up to the Guaranteed Issue Amount, without providing evidence of good health. If you apply for an amount of coverage greater than the Guaranteed Issue Amount, coverage in excess of the Guaranteed Issue Amount will not be issued until the insurance company approves acceptable evidence of good health. If you apply for coverage for yourself more than 31 days from the date you become eligible to elect coverage under this plan, the Guaranteed Issue Amount will not apply, unless Guaranteed Issue has been approved by your employer for a specific period of time. Coverage will not be issued until the insurance company approves acceptable evidence of good health.

These are summarized definitions only. To be eligible for coverage, the covered illness or event must meet the definitions and other terms and conditions set forth in the group policy.

THIS POLICY PROVIDES LIMITED COVERAGE. IT PAYS A FIXED BENEFIT AND DOES NOT COVER MEDICAL EXPENSES AS INCURRED. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE OR MAJOR MEDICAL HEALTH INSURANCE. THIS COVERAGE DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT BECAUSE THE COVERAGE DOES NOT MEET THE REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

Terms and conditions of coverage for Term Life insurance are set forth in Group Policy No. SGM 600963. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, eligible conditions, their respective payments and policy exclusions and limitations are contained in the Policy. Please see your Plan Sponsor to obtain a copy of the Policy. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability, costs, benefits, riders, covered conditions and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192.

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Offered by Life Insurance Company of North America, a Cigna company

Employer-Paid ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

SUMMARY OF BENEFITS

Prepared for: Town of Los Gatos

If you pass away or are seriously injured as a result of a covered accident or injury, you or your beneficiaries will receive a set amount to help pay for unexpected expenses, or help your loved ones pay for future expenses after you're gone.

Who Is Eligible For Coverage?:

You: All active, full-time Employees and Elected Officials of the Employer regularly work a minimum of 20 hours per week. You will be eligible for coverage immediately.

Available Coverage:

	Benefit Amount	Maximum
Employee	\$50,000	\$50,000

Benefit Details:

If, within 365 days of a Covered Accident, bodily injuries result in:	We'll pay this % of the Benefit Amount:
Loss of life; Total paralysis of both upper and lower limbs; Loss of two or more hands or feet; Loss of sight in both eyes; or Loss of speech and hearing (both ears)	100%
Total paralysis of both lower limbs or both upper limbs	75%
Total paralysis of upper and lower limbs on one side of the body; Loss of one hand, one foot, sight in one eye, speech, or hearing in both ears; or Severance and Reattachment of one hand or foot	50%
Total paralysis of one upper or one lower limb; Loss of all four fingers of the same hand; or Loss of thumb and index finger of the same hand	25%
Loss of all toes of the same foot	20%

For Comas – You will receive 1% of the full benefit amount each month, for up to a maximum of 11 months, if you or an insured family member are in a coma for 30 days or more as a result of a Covered Accident. If the covered person is still in a coma after 11 months, or dies, the full benefit amount will be paid.

Additional Features:

For Wearing a Seatbelt & Protection by an Airbag – You will receive an additional 10% benefit but not more than \$5,000 if the covered person dies in a covered automobile accident and law enforcement-certified to be wearing a seatbelt or approved child restraint. We will increase the benefit by an additional 5% but not more than \$2,500 if the insured person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

For Exposure & Disappearance – Benefits are payable if you or an insured family member suffer a covered loss due to unavoidable exposure to the elements as a result of a Covered Accident. If your or an insured family member's body is not found within one year of the disappearance, wrecking or sinking of the conveyance in which you or an insured family member were riding, on a trip otherwise covered, it will be presumed that you sustained loss of life as a result of a Covered Accident.

Conversion – If group accident coverage ends (except due to nonpayment of premium), your employment is terminated, membership in an eligible class is terminated, or insurance coverage is reduced based on attained age, you can convert to an individual non-term policy. To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends. Dependents may convert their coverage as well if applicable. Premiums may change at this time, and terms of coverage will be subject to change. You can also convert to an individual policy of up to \$10,000 if you have been insured for at least 3 years and the policy is terminated or amended, provided coverage is not replaced and you are not covered under a different conversion policy issued by Life Insurance Company of North America. Refer to your certificate for details.

Important Definitions and Policy Provisions:

When your coverage begins – Coverage begins on the later of the program's effective date, the date you become eligible, the date we receive your completed enrollment form if applicable, or the date you authorize any necessary payroll deductions if applicable. Your coverage will not begin unless you are actively at work on the effective date. Dependent coverage, if applicable, will not begin for any dependent who on the effective date is hospital or home confined; receiving chemotherapy or radiation treatment; or disabled and under the care of a physician.

When your coverage ends – Coverage ends on the earliest of the date you or your dependents, if applicable, are no longer eligible, the date the group policy is no longer in force, or the date for the last period for which required premiums are paid. (Under certain circumstances, your coverage may be continued if you stop working. Be sure to read the Continuation of Insurance provisions in your Certificate.)

Benefit Reductions, Exclusions and Limitations

Benefit Reduction Schedule: If you are still employed, your benefits will reduce to 67% at age 65 and 45% at age 70. Your premiums will also reduce to match your benefits.

Exclusions – Self-inflicted injuries or suicide while sane or insane • commission or attempt to commit a felony or an assault • any act of war, declared or undeclared • any active participation in a riot, insurrection or terrorist act • bungee jumping • parachuting • skydiving • parasailing • hang-gliding • sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food • voluntarily using any drug, narcotic, poison, gas or fumes except one prescribed by a licensed physician and taken as prescribed • operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the covered person has been provided a written warning against operating a vehicle while taking it • a Covered Accident that occurs while the covered person is engaged in the activities of active duty service in the military, navy or air force of any country or international organization (this does not include Reserve or National Guard training, unless it extends beyond 31 days) • traveling in an aircraft that is owned, leased or controlled by the sponsoring organization or any of its subsidiaries or affiliates • air travel, except as a passenger on a regularly scheduled commercial airline or in an aircraft being used by the Air Mobility Command or its foreign equivalent • flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth’s surface being flown by the covered person or in which the covered person is a member of the crew.

Limitations – For multiple covered losses, benefits are paid for the single largest benefit available. For loss of life, the benefit amount shown will be reduced by the amount of any dismemberment benefits that were previously paid or payable.

THIS POLICY PROVIDES LIMITED ACCIDENT-ONLY COVERAGE. IT PAYS A FIXED BENEFIT AND DOES NOT COVER MEDICAL EXPENSES AS INCURRED. IT DOES NOT COVER LOSSES CAUSED BY SICKNESS. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE OR MAJOR MEDICAL HEALTH INSURANCE.

Terms and conditions of coverage for Accidental Death and Dismemberment insurance are set forth in Group Policy No. SOK 600465. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, eligible injuries, their respective payments and policy exclusions and limitations are contained in the Policy Certificate. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192

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Employee-Paid Term Life Insurance

Developed for the Employees of
Town of Los Gatos



Who Needs Life Insurance?

You do. Single or married. Buying your first home or preparing for retirement. Raising children or sending them off to college. No matter where you are in life, insurance should be part of your financial plan.

By purchasing this insurance product through your employer, you benefit from:

- Affordable group rates
- Convenient payroll deduction
- Access to knowledgeable service representatives.

Who Is Eligible For Coverage?

You — If you are an active, full-time employee or an elected official of the employer and work a minimum of 20 hours per week for your employer.

Your Spouse* — Up to age 70 is eligible provided that you apply for and are approved for coverage for yourself.

Your Unmarried, Dependent Children — At least 14 days old and under age 19 (or under age 25 if they are full-time students), as long as you apply for and are approved for coverage for yourself. One low premium will insure all your eligible children, regardless of the number of children you have. No one may be covered more than once under this plan. If covered as an employee, you can not also be covered as a dependent.

**Domestic Partner is defined in the group policy. For purposes of this brochure, wherever the term Spouse appears it shall also include Domestic Partner. You must have on file an affidavit (available from your employer) which specifies the criteria for being considered a Domestic Partner under the group policy. In addition, a Domestic Partner registered with the California Secretary of State is eligible as a Domestic Partner under the policy, and no affidavit is necessary. Additional information is available from your Benefit Services Representative.*

Guaranteed Coverage

If you and your dependents are eligible and you apply during the initial enrollment period, or within 31 days after you are eligible to elect coverage, you are entitled to choose any of the offered amounts of coverage up to the guaranteed coverage amount, as shown on your application, without having to provide evidence of good health. If you apply for an amount of coverage for yourself or your spouse greater than the guaranteed coverage amount, coverage in excess of the guaranteed coverage amount will not be issued until the insurance company approves acceptable evidence of good health. Evidence of good health may include a paramedical exam or physician's statement. If you apply for coverage for yourself or your spouse more than 31 days from the date you become eligible to elect coverage under this plan, the guaranteed coverage amounts will not apply. Coverage will not be issued until the insurance company approves acceptable evidence of good health. Evidence of good health may include a paramedical exam or physician's statement.

How Much Coverage Can You Buy?

You — You can select life insurance coverage in units of \$10,000. The maximum for any employee is the lesser of 5 times your annual salary or \$300,000. The guaranteed coverage amount for you is the lesser of 1 times your annual salary or \$100,000.

Your Spouse — You may select coverage for your spouse in units of \$5,000 to a maximum of \$250,000. The cost of coverage will be based on your spouse's age. The guaranteed coverage amount for your spouse is \$25,000.

Your Unmarried, Dependent Children — You may select coverage for your unmarried, dependent children in units of \$1,000 to a maximum of \$10,000. The maximum benefit for children under six months is \$500. The guaranteed coverage amount for your child(ren) is \$10,000.

How Much Your Coverage Will Cost

The monthly cost of insurance for you and your spouse will depend on your ages and the amount of insurance you wish to purchase. As shown in the following chart, the cost of insurance increases with the age of the insured. Note that at age 60, your benefits are reduced. Spouse coverage ceases at age 70.

To calculate your monthly cost:

1. Find your age group in the following table;
2. Multiply the rate by the number of coverage units you want;
3. Calculate the cost of coverage for your spouse, using your spouse's age, then calculate the cost of coverage for your children;
4. Add the premiums for you, your spouse and your children to get your total monthly cost.

Example::				
Employee (age 28)	25 units (\$250,000)	x	\$0.60 per unit	= \$15.00
Spouse (age 24)	10 units (\$50,000)	x	\$0.245 per unit	= \$2.45
Children	10 units (\$10,000)	x	\$0.18 per unit	= \$1.80
Total Monthly Cost				\$19.25

To calculate your cost, complete this chart:

Employee	___ units	x	\$___ per unit	= \$___
Spouse	___ units	x	\$___ per unit	= \$___
Children	___ units	x	\$0.18 per unit	= \$___
Total Monthly Cost				\$___

Employee/ Spouse Age	Employee Monthly Cost per \$10,000 Unit	Spouse Monthly Cost per \$5,000 Unit
Under 20	\$0.31	\$0.155
20 to 24	0.49	0.245
25 to 34	0.60	0.30
35 to 39	0.79	0.395
40 to 44	1.05	0.525
45 to 49	1.58	0.79
50 to 54	2.51	1.255
55 to 59	4.04	2.02
60 to 64	6.20	3.10
65 to 69	10.50	5.25
70 to 74	19.93	--
75 to 79	40.26	--
80 to 84	79.98	--
85 to 89	147.44	--
90 to 94	240.57	--
95 to 99	365.17	--

The monthly cost for children is \$0.18 per \$1,000 of coverage. One premium will insure all your eligible children, regardless of the number of children you have.

Costs are subject to change.

When You Reach Age 65

By the time you reach age 65, chances are that your children will be grown and your mortgage paid. At age 65, providing you are still employed, your coverage will decrease to 67% of the benefit amount. It will decrease to 45% at age 70. Premiums and coverage for your spouse will end at age 70; at that time your spouse may choose to convert this coverage to a permanent life insurance policy.

Other Benefit Features

Accelerated Death Benefit — Terminal Illness

If you or your spouse is diagnosed by two unaffiliated physicians as terminally ill with a life expectancy of 12 months or less, the accelerated payment benefit for terminal illness provides for up to 50% of the life insurance coverage amount in force or \$250,000, whichever is less, to be paid to the insured. This benefit is payable only once in the insured's lifetime, and will reduce the life insurance death benefit.

The terminal illness benefit may be taxable. As with all tax matters, an insured should consult with a personal tax advisor to assess the impact of this benefit.

Increasing Your Coverage

You may increase your coverage at any time. We do require evidence of good health for all new coverage elections.

Continuation for Disability for Employees Age 60 or over

If your active service ends due to disability, this plan provides a continuation of coverage feature. If you are disabled at age 60 or over, your coverage will continue while you are disabled. This benefit will remain in force until the earliest of the following dates: the date you are no longer disabled, the date the policy terminates, the date you are Disabled for 9 consecutive months, or the day after the last period for which premiums are paid.

You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your Regular Occupation, or you are receiving disability benefits under your Employer's plan. "Regular Occupation" means your occupation, as routinely performed in the general labor market, at the time your disability begins.

Extended Death Benefit with Waiver of Premium

Extended Death Benefit

If you become Disabled — The extended death benefit ensures that if you become disabled prior to age 60, and die before you qualify for Waiver of Premium, we will pay the life insurance benefit if you remain disabled during that period. If you qualify for this benefit and have insured your spouse or children, their coverage is also extended.

You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your Regular Occupation, or you are receiving disability benefits under your Employer's plan. "Regular Occupation" means your occupation, as routinely performed in the general labor market, at the time your disability begins.

Waiver of Premium

If you become totally disabled — To make sure you can keep the life insurance protection you need during a difficult period of your life, this plan provides a *waiver of premium* feature. If you are totally disabled prior to age 60 and can't work for at least 6 months, you won't need to pay premiums for your coverage while you are disabled, provided the insurance company approves you for this benefit. You are considered totally disabled when you are completely unable to engage in any occupation for wage or profit because of injury or sickness. This benefit will remain in force until age 65, subject to proof of continuing disability each year. If you qualify for this benefit and have insured your spouse or children, the premium for their coverage is also waived.

What Is Not Covered

The plan will not pay benefits if loss of life is the result of suicide that occurs within the first two years of coverage.

When Your Coverage Begins and Ends

The date your coverage begins is called its "effective date." Your employer will let you know the effective date of your coverage. If you are not actively at work on the effective date of coverage, your coverage will not begin until you return to work.

For coverage for your spouse and/or children to be effective, they must not be hospitalized or confined at home under the care of a doctor.

Your coverage cannot be terminated as long as you remain eligible, the premium is paid and the group policy remains in force.

For your spouse and children, coverage ends when your coverage ends, when their premiums are not paid or when they are no longer eligible.

If You Leave Your Employer

To help you keep your life insurance coverage during the years when your family needs financial protection, the plan allows you to continue all of your voluntary coverage if you leave your employer. Premiums may change at this time. Just make arrangements to pay your premiums directly to the insurance company after you leave your current employer. Coverage may be continued for you and your spouse until age 70. Coverage may also be continued for your children. As long as the group policy remains in force, the option of continuing this coverage is available.

Converting Your Coverage to Permanent Life Insurance

If group life insurance coverage is reduced or ends for any reason except nonpayment of premiums, you can convert to an individual policy. No medical certification is needed. To convert coverage, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends. Family members may convert their coverage as well. Converted policies are subject to certain benefits and limits as outlined in the conversion brochure which may be requested as needed. Premiums may change at this time.

Apply Today

In order to apply for coverage, you must complete an application form. Be sure to answer all questions accurately, and indicate how much coverage you wish to have.

Payroll Deduction

You pay your premiums through payroll deduction. The total depends on how much coverage you select, your age, your spouse's age and the amount of coverage you buy for your spouse and children.

Designating Your Beneficiary

Your term life benefit will automatically be paid to the first beneficiary listed below who is living at the time of your death if you do not designate a specific beneficiary:

- 1) Your Spouse*
- 2) Your Child(ren)
- 3) Your Parents
- 4) Your Siblings
- 5) Your Estate

If you wish to designate different beneficiaries, or to indicate percentages, you may do so on your application. If the listed beneficiary is a trustee or a trust, you will need to indicate the trustee's name, the name of the trust and the date of the trust agreement. The trust document must be presented in order for the claim to be processed.

** Benefits will not be paid to your Domestic Partner if he or she is not specifically designated.*

How Your Claims Are Paid

Your employer has all the forms your beneficiary will need and can provide assistance in completing them.

Questions?

Cigna Group Insurance has courteous, knowledgeable customer service representatives who can assist you with the completion of your enrollment form by calling 1-800-732-1603 toll-free anytime from Monday through Friday, 8 a.m. to 6 p.m. Eastern time. Cigna does not have your coverage election information on file. For specific benefit/account inquiries on what is available under your plan, please contact your Human Resources department.

This information is a brief description of important features of the plan. It is not a contract. Terms and conditions of coverage are set forth in Group Policy No. SGM-600963, on Policy Form TL-004700, issued in Delaware to the Trustee of the Group Insurance Trust for Employers in the Public Administration Industry. The group policy is subject to the laws of the jurisdiction in which it is issued. The availability of this offer may change. Please keep this material as a reference.

*Coverage is underwritten by
Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, PA 19192*





Offered by Life Insurance Company of North America, a Cigna company

Employer-Paid SHORT-TERM DISABILITY INSURANCE

SUMMARY OF BENEFITS

Prepared for: Town of Los Gatos

Disability insurance pays a portion of your salary if you're unable to work due to a covered disability. When reviewing this coverage, consider how long you can personally go without receiving a paycheck.

Who Is Eligible For Coverage?:

You: All active, full-time Employees and Elected Officials of the Employer regularly work a minimum of 20 hours per week.
You will be eligible for coverage immediately.

Available Coverage:

Gross Weekly Benefit ¹	Maximum Gross Weekly Benefit	Benefit Waiting Period	Maximum Benefit Period
60% of your weekly covered earnings	\$1,300	7 Days for accident 7 Days for sickness	13 Weeks for accident 13 Weeks for sickness

Important Definitions and Policy Provisions:

Disability - "Disability" or "Disabled" means if solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation or you are unable to earn 80% or more of your covered earnings from working in your regular occupation. We will require proof of earnings and continued disability.

Covered Earnings - "Covered Earnings" means your wages or salary, not including overtime pay, bonuses, commissions, and other extra compensation.

When Benefits Begin - You must be continuously Disabled for 7 Days for an accident and 7 Days for a sickness before benefits will be paid for a covered Disability.

How Long Benefits Last - Once you qualify for benefits under this plan, the maximum number of weekly Disability benefits is 13 Weeks for an accident and 13 Weeks for a sickness. Disability benefits will end sooner if you no longer qualify for benefits.

When Coverage Takes Effect - Your coverage takes effect on the plan or policy effective date, the date you become eligible, the date we receive your completed enrollment form, or the date you authorize any necessary payroll deductions, whichever is the latest date. If you're not actively at work on the date your coverage would otherwise take effect, your coverage will take effect on the date you return to work. If you have to submit evidence of good health, your coverage takes effect on the date we agree, in writing, to cover you.

Benefit Reductions, Conditions, Limitations and Exclusions:

Effects of Other Income Benefits - This plan is structured to prevent your total benefits and post-disability earnings from equaling or exceeding pre-disability earnings. Therefore, we reduce this plan's benefits by an amount equal to any Social Security retirement and/or disability benefits payable to you, your dependents, or a qualified third party on behalf of you or your dependents. Your disability benefits will not be reduced by any Social Security disability benefits you are not receiving as long as you cooperate fully in efforts to obtain them and agree to repay any overpayment when and if you do receive them. Disability benefits will be reduced by amounts received through other government programs, sick pay, employer funded retirement benefits, workers' compensation, franchise/group insurance, auto no-fault, and damages for wage loss. For details, see your Certificate of Insurance.

Termination of Disability Benefits - Your benefits will terminate when your Disability ceases, when your benefit duration period is exceeded, you earn more than your allowable Covered Earnings, or the date you refuse to participate in rehabilitation services.

Exclusions - This plan does not pay benefits for a Disability which results, directly or indirectly, from any of the following:

- Suicide, attempted suicide, or intentionally self-inflicted injury while sane or insane.
- war or any act of war, whether or not declared.
- active participation in a riot;
- commission of a felony;
- the revocation, restriction or non-renewal of an Employee's license, permit or certification necessary to perform the duties of his or her occupation unless due solely to Injury or Sickness otherwise covered by the Policy.
- any cosmetic surgery or surgical procedure that is not Medically Necessary.
- an Injury or Sickness for which the Employee is entitled to benefits from Workers' Compensation or occupational disease law.
- an Injury or Sickness that is work related.

In addition, the plan does not pay disability benefits any period of Disability during which you are incarcerated in a penal or corrections institution.

1. Your benefit amount will be reduced by any amounts payable to you by any of the sources listed under the "Effects of Other Income Benefits" section.
2. Costs are subject to change.

Terms and conditions of coverage for Short Term Disability insurance are set forth in Group Policy No. SGD 600829. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, are contained in the Policy Certificate. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192.

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Offered by Life Insurance Company of North America, a Cigna company

Employer-Paid LONG-TERM DISABILITY INSURANCE

SUMMARY OF BENEFITS

Prepared for: Town of Los Gatos

If you had an unexpected illness or injury and were unable to work, how long would you be able to pay your bills? Long-term disability pays a portion of your salary if you're unable to work due to a covered disability.

Who Is Eligible For Coverage?:

You: All active, Full-time Employees of the Employer regularly working a minimum of 20 hours per week excluding Employees who are classified as Elected Officials.

You will be eligible for coverage immediately.

Available Coverage:

Gross Monthly Benefit ¹	Maximum Gross Monthly Benefit	Benefit Waiting Period	Maximum Benefit Period
60% of your monthly covered earnings	\$6,000	90 Days	Please refer to the "How Long Benefits Last" section below for more details.

Additional Features

Family Survivor Benefit – If you die while receiving benefits, we will pay a survivor benefit to your lawful spouse, eligible children, or estate. The plan will pay a single lump sum equal to 3 months of benefits.

Important Definitions and Policy Provisions:

Disability - "Disability" or "Disabled" means that, solely because of a covered injury or sickness, you are unable to perform the material duties of your regular occupation/regular job or you are unable to earn 80% or more of your indexed earnings from working in your regular occupation/regular job. After benefits have been payable for 24 months, you are considered disabled if solely due to your injury or sickness, you are unable to perform the material duties of any occupation for which you are (or may reasonably become) qualified by education, training or experience, or you are unable to earn 60% or more of your indexed earnings. We will require proof of earnings and continued disability.

Covered Earnings - "Covered Earnings" means your wages or salary, not including overtime pay, bonuses, commissions, and other extra compensation.

When Benefits Begin - You must be continuously Disabled for 90 Days before benefits will be paid for a covered Disability.

How Long Benefits Last - Once you qualify for benefits under this plan, you continue to receive them until the end of the benefit or until you no longer qualify for benefits, whichever occurs first. Should you remain Disabled, your benefits continue according to the later of your Social Security Normal Retirement Age, or the following schedule, depending on your age at the time you become Disabled.

Age at Disability	Age 62 or younger	63	64	65	66	67	68	69+
Duration of Payments (months)	To age 65 or the date the 42nd monthly benefit is payable, if later.	36	30	24	21	18	15	12

When Coverage Takes Effect - Your coverage takes effect on the later of the policy's effective date, the date you become eligible, the date we receive your completed enrollment form, or the date you authorize any necessary payroll deductions. If you're not actively at work on the date your coverage would otherwise take effect, your coverage will take effect on the date you return to work. If you have to submit evidence of good health, your coverage takes effect on the date we agree, in writing, to cover you.

Benefit Reductions, Conditions, Limitations and Exclusions:

Effects of Other Income Benefits - This plan is structured to prevent your total benefits and post-disability earnings from equaling or exceeding pre-disability earnings. Therefore, we reduce this plan's benefits by an amount equal to any Social Security retirement and/or disability benefits payable to you, your dependents, or a qualified third party on behalf of you or your dependents. Your disability benefits will not be reduced by any Social Security disability benefits you are not receiving as long as you cooperate fully in efforts to obtain them and agree to repay any overpayment when and if you do receive them. Disability benefits will be reduced by amounts received through other government programs, sick pay, employer funded retirement benefits, workers' compensation, franchise/group insurance, auto no-fault, and damages for wage loss. For details, see your outline of coverage, policy certificate, or your employer's summary plan description.

Earnings While Disabled - During the first 24 months that benefits are payable, benefits will be reduced if benefits plus income from employment exceeds 100% of pre-disability Covered Earnings. After that, benefits will be reduced by 50% of earnings from employment.

Limited Benefit Period - Disabilities caused by or contributed to by any one or more of the following conditions are subject to a lifetime limit of 24 months for outpatient treatment: Anxiety-disorders, delusional (paranoid) or depressive disorders, eating disorders, mental illness, somatoform disorders (including psychosomatic illnesses), Alcoholism, drug addiction or abuse. Benefits are payable during periods of hospital confinement for these conditions for hospitalizations lasting more than 14 consecutive days that occur before the 24-month lifetime outpatient limit is exhausted.

Termination of Disability Benefits - Your benefits will terminate when your Disability ceases, when your benefit duration period is exceeded, you earn more than your allowable Covered Earnings, or the date you refuse to participate in rehabilitation services.

Exclusions - This plan does not pay benefits for a Disability which results, directly or indirectly, from any of the following: • Suicide, attempted suicide, or intentionally self-inflicted injury while sane or insane. • war or any act of war, whether or not declared. • active participation in a riot; • commission of a felony; • the revocation, restriction or non-renewal of an Employee's license, permit or certification necessary to perform the duties of his or her occupation unless due solely to Injury or Sickness otherwise covered by the Policy. • any cosmetic surgery or surgical procedure that is not Medically Necessary.

In addition, the plan does not pay disability benefits any period of Disability during which you are incarcerated in a penal or corrections institution.

- 1 Your benefit amount will be reduced by any amounts payable to you by any of the sources listed under the "Effects of Other Income Benefits" section.
- 2 Costs are subject to change.

Terms and conditions of coverage for Long Term Disability insurance are set forth in Group Policy No. SGD 600830. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, are contained in the Policy Certificate. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability and/or features may vary by state.

Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192.

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CIGNA HEALTHY WORKING LIFESM

PRE-DISABILITY VOCATIONAL SERVICES

Participant guide

People with medical conditions, who do not lose time from work, may have better health outcomes than people who do lose time. One of the keys to reducing the incidence of disability is early intervention – ideally before your employee even needs to file a disability claim. The conditions that lead to work absence are often known and under medical care months before a disability claim is filed.

That's why Cigna offers a stay-at-work solution to our disability clients – services designed to help your at-risk employees reduce the likelihood of going out on disability. Our Vocational Coaches help employees who have serious medical conditions remain at work and productive by better managing the limitations associated with their conditions.

While not all disabilities can be predicted or avoided, Cigna understands that many of the conditions that lead to work absence are often known and under medical care months before a disability claim is filed.

Pre-disability interventions are provided by Vocational Coaches to employees who are at risk for a disability absence but have not gone out of work yet.

What does a Vocational Coach do?

Vocational Coaches are part of the Cigna disability management team and are experts in:

- ▶ Assessing employees' skills, functional capacity and motivation, and then matching them to the requirements of a given job.
- ▶ Providing counseling and technical assistance to employees who may be struggling with illnesses or injuries that affect their ability to work.

- ▶ Training employers to meet the needs of employees with disabling conditions.
- ▶ Assessing an employee's needs, abilities and medical restrictions that will affect his or her ability to perform job tasks.
- ▶ Identifying barriers that may be preventing an employee from staying at work or returning to work.
- ▶ Providing one-on-one Coaching to help employees overcome those barriers.
- ▶ Identifying opportunities for:
 - Job task modifications.
 - Workstation ergonomic adjustments.
 - Transitional work assignments.
 - Assistive devices or attire.
- ▶ Collaborating with other health care professionals to support the employee's participation within their treatment plan.

The particular services provided depend on the employee's serious medical condition and other factors as determined by the Vocational Coach.

Together, all the way.SM



Offered by: Life Insurance Company of North America or Cigna Life Insurance Company of New York.

Based on the Vocational Coach's assessment, Cigna may engage a range of interventions that might include performing ergonomic assessments or authorizing payment for workplace equipment.

Who can benefit from pre-disability vocational services?

While the particular medical conditions that make someone suitable for these services are too varied to list, some signs that an individual may be a candidate for referral may include the following.

1. Is the employee experiencing increased absence due to his/her condition (calling out sick more or coming in late or leaving early)?
2. Does the employee have a past history of disability absence due to his/her condition?
3. Does the employee seem to be struggling to complete his/her job tasks?
4. Does the employee complain of pain or discomfort?
5. Has the employee requested replacement equipment, such as a different office chair, in order to be more comfortable?

Employees who would not be appropriate for pre-disability vocational services include:

- Individuals currently out of work on disability.
- Workers' compensation cases.
- Employees experiencing temporary pain/discomfort not due to a serious medical condition.

Getting started – it's easy!

Everything you need to know about how to use this program can be found on our orientation website at **Cigna.com/predisability**.

For any additional questions about Healthy Working Life services please contact your account manager.

How to make a referral for pre-disability vocational services

STEP 1:

- When a Human Resources representative, your health clinic staff (if you have them) or the employee's manager identifies someone that appears to be a candidate for pre-disability vocational services, first talk with the employee about what you have noticed.
- Tell the employee that Cigna may be able to help, and ask if the employee would like to be referred to a Vocational Coach for assistance.
- Offer interested employees our customer FAQ flyer which explains in simple terms what a Vocational Coach does and how they can help.

STEP 2:

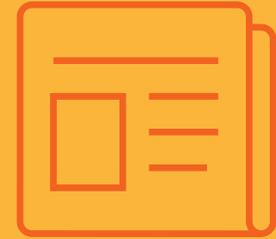
- Use the referral form located on the orientation website to make the referral and provide some basic information about the employee to the Vocational Coach.
- Have the employee sign a "Cigna Release of Information Authorization" (located on the orientation website). We must have the employee's authorization to begin working with him or her.
- Return the completed referral form and authorization form to Cigna by email to: **PreDisability@Cigna.com** or fax it to: **860.731.3049**.

STEP 3:

- Once the referral is received, a Vocational Coach will confirm receipt of the referral with you. The Coach will contact the employee directly to complete the initial assessment.
- When you make the referral, reassure the employee that he or she will be contacted by the Vocational Coach to set up an appointment and discuss their situation privately. We'll do the rest.



WILL PREPARATION



Plan for your family's future and financial well-being.

Sixty-four percent of Americans do not have a will.* That means that they have little or no control over decisions after they die. It also leaves a burden on family members. They must make hard choices at an emotional time. Advance planning helps to make the process easier. And Cigna's Will Center can help you with the planning process.

Getting started is easy

Go to **CignaWillCenter.com**. It's easy to use and available to you and your spouse anytime day or night. Once you're registered on the site, you can:

- **Get resources and tools to help you plan** and learn more about:
 - Will preparation
 - Estate planning
 - Funeral planning
- Create a central location to store important information for easy access
- **Create state-specific, legal documents online**, including:
 - Last will and testament
 - Living will
 - Financial power of attorney
 - Power of attorney for health care
 - Medical treatment authorization for minors

➤ **Manage your legal documents.** You can:

- Preview
- Edit
- Download
- Print



Service representatives are available to help you at **1.800.901.7534****



Visit **CignaWillCenter.com** today.

For help, call **800.901.7534.****

Representatives are available between 7:00 AM and 7:00 PM (CST).

Or you can email a help request to **Service@ARAGdirect.com**.

*"Perspectives on Wills," conducted by ARAG, April 2013

** No legal advice is provided

Together, all the way.SM



Registrations and customized documents are maintained for two years, which allows individuals to easily make revisions to their legal documents as their personal situation changes.

Will preparation services are independently administered by ARAG®. Cigna does not provide legal services and makes no representations or warranties as to the quality of the information on the ARAG website or the services of ARAG.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Life Insurance Company of North America, Cigna Life Insurance Company of New York, and Connecticut General Life Insurance Company. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

PROVIDING PEACE OF MIND DURING A TIME OF NEED

Cignassurance Program for beneficiaries

If the unexpected happens, the Cignassurance® Program can help. Available with Cigna Life and Accidental Death and Dismemberment¹ plans, this program provides financial, bereavement and legal support for your loved ones during their time of need. As a beneficiary of your Life and/or Accident plan, they'll get:

- › Free and confidential bereavement services over the phone, with licensed clinicians and nurses available 24/7.
- › Two free face-to-face counseling sessions with a local Cigna Behavioral Health network therapist.²
- › 30 minutes of free legal advice with a licensed practicing attorney over the phone.² And referrals to discounted, professional legal services for help with estate planning, preparing a will or general advice.³
- › 30 minutes of free financial services advice from a qualified financial professional over the phone.² Additional referrals to financial professionals who can assist with other financial needs.
- › Access to a Cignassurance account – a free, interest-bearing account for proceeds over \$5,000. This account keeps their insurance proceeds in a safe place and gives them time to deal with more pressing issues. Account balances and activity can be managed 24/7 at Cignassurance.com.
- › Our **Looking Ahead** guidebook to help your loved ones navigate legal and financial responsibilities and research additional benefits.

Together, all the way.®



1. The Cignassurance Program for beneficiaries is available to beneficiaries receiving coverage checks over \$5,000 from Cigna Group Life and Personal Accidental Death and Dismemberment Programs. Cignassurance accounts are not deposit account programs and are not insured by the Federal Deposit Insurance Corporation or any other federal agency. Account balances are the liability of the insurance company and the insurance company reserves the right to reduce account balances for any payment made in error.

2. Phone and face-to-face counseling sessions must be used within one year of the date the claim is approved. Counseling, legal or financial assistance programs are not available under policies insured by Cigna Life Insurance Company of New York.

3. Additional charges may apply.

Financial, bereavement and legal services are independently administered by CLC Incorporated (CLC). Cigna does not provide financial/legal services and makes no representations or warranties as to the quality of the information on the CLC website or the services of CLC.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Life Insurance Company of North America and Cigna Life Insurance Company of New York. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

CIGNA IDENTITY THEFT PROGRAM



Your identity cannot be replicated, but it can be stolen.

Identity Theft occurs when someone uses your personal identifying information, like your name, Social Security number, or credit card number, without your permission, to commit fraud or other crimes. It's America's fastest growing crime, victimizing about 12.7 million people in 2014.* Cigna's Identity Theft program is available to help if this serious crime impacts you.

Valuable help before and after identity theft.

Our identity theft program provides tools and guidance to help with prevention, detection and resolution. This includes:

- › Education on how to identify and avoid identity theft before it happens
- › An identity theft protection kit that provides the right documents to use and steps to follow if your identity has been compromised
- › Help to complete an identity theft affidavit and cancel lost credit cards
- › Guidance to help you replace credit cards, a driver's license, Social Security card, passport, etc.
- › Assistance with understanding your credit reports to determine if identity theft has occurred, and help with reporting an identity theft to credit reporting agencies
- › Help with emergencies while traveling, including translation services with local authorities, filing a police report, and emergency message relay
- › Up to \$500 cash advance if your wallet or purse is stolen when traveling more than 100 miles from home**

Not sure how to get started?

If you become a victim of identity theft, Cigna's program is here for you.

- › Get assistance with credit card fraud, and financial or medical identity theft
- › Receive real-time, one-on-one assistance — 24 hours a day, 365 days a year – no matter where you are in the world***
- › You'll have unlimited access to our personal case managers until your problem is resolved

If you suspect you might be a victim of identity theft, call 1.888.226.4567 (U.S. and Canada) or 202.331.7635. Personal case managers are standing by to help you. Please indicate that you are a member of the Cigna identity theft program and group #57.



* Javelin Strategy and Research, March, 2014.

** When the theft occurs 100 miles or more from primary residence. Must be secured by a valid credit card and repaid by customer within 30 days, or fees/charges will apply.

*** Assistance with U.S. bank accounts only.

Together, all the way.SM



Offered by: Connecticut General Life Insurance Company, Life Insurance Company of North America or Cigna Life Insurance Company of New York.

Cigna Identity Theft Program services are provided under a contract with Europ Assistance USA. Presented here are highlights of the identity theft program. Full terms, conditions and exclusions are contained in applicable service agreement. This program is NOT insurance and does not provide for reimbursement of financial losses.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Connecticut General Life Insurance Company, Life Insurance Company of North America, and Cigna Life Insurance Company of New York. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

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Your life's journey—made easier

No matter where you are on your journey, there are times when a little help can go a long way. From checking off daily tasks to working on more complex issues, your program offers a variety of resources, tools and services available to you and your household members.

Your program is here to help you along the journey of life. No situation is too big or too small. When you and your household members need assistance, reach out anytime and we will help get you on the right path to meet your needs.

Key features

- Provided at no cost
- Includes up to 8 counseling sessions
- Confidential service provided by a third party
- Available 24/7/365

Core services

- *Counseling*—Counselors can provide support for challenges such as stress, anxiety, grief, relationship concerns and more.
- *Coaching*—When you have a goal to achieve, coaches help you create a plan of action and stay on track.
- *Online programs*—Self-guided, interactive programs help improve your emotional well-being for issues like depression and anxiety.

Here's how to get started

Getting the help you need, when you need it, can result in you leading a happier, more productive life.

-  Give us a call and we will connect you with the right resource or professional.
-  Learn more about all of the services available at MagellanAscend.com.

Legal assistance, financial coaching & identity theft resolution

Expert consultation to help with your legal, financial and identity theft needs. Access a free online library with resources for identity theft resolution, budgeting, debt management, family law, wills and more.

Work-life services

Save time and money on life's most important needs. Specialists provide expert guidance and personalized referrals to service providers including childcare, adult care, education, home improvement, consumer information, emergency preparedness and more.

Wellness resources

Eat better, move more, be happier and healthier with wellness resources including:

- Interactive tools and assessments
- Educational articles and engaging videos
- Information on fitness, proper eating, weight management, disease and injury prevention

**Employee Assistance Program
For Professional Consultation**

Call 1-800-523-5668

For TTY Users: 1-800-456-4006



Section 125 Plan & Flexible Spending Accounts

AMERICAN FIDELITY

a different opinion



™

An Easy Way to Pay for Expenses

A Section 125 Plan provides a tax-saving way to pay for eligible medical or dependent care expenses. The funds are automatically deducted from your paycheck before income tax is applied. Simply choose the amount to be deducted, and the funds are set aside to be used for eligible expenses throughout the year.

Here's How It Works

A Section 125 Plan reduces your tax and increases your spendable income by allowing you to deduct the cost of eligible benefits from your earnings before tax. Plus, the plan is available to you at no cost, and you're already eligible. All you have to do is enroll.

Is It Right for Me?

The savings you may experience with a Section 125 Plan are outlined below. By utilizing the Section 125 Plan, Jane would have \$70 more every month to apply toward her insurance benefits or other needs. That's a savings of \$840 a year.

Ready to Enroll?

To enroll in the Section 125 Plan, just complete an election form. You'll receive plenty of advance notice when it's time to enroll. And, in most cases, you must re-enroll each year to keep participating in the plan.

How to Make Election Changes

You're able to change your election each year during your annual benefits enrollment, but the only time Internal Revenue Code regulations allow you to make a change during the plan year itself is if you experience a qualified event. Some examples include:

- **Change in legal married status**
- **Change in number of dependents**
- **Termination or commencement of employment**
- **Dependent satisfies or ceases to satisfy dependent eligibility requirements**
- **Change in residence or worksite that affects eligibility for coverage**

These examples may not be all-inclusive. Please contact your employer for guidance with your specific situation.

Employee Name: Smith, Jane
SSN: 123-45-XXXX Payment Date: 1/1/17
Employee Number: 0515 Period Begin Date: 1/30/17

Earnings & Hours

	Without S125	With S125
Monthly Salary	\$2,000	\$2,000
Medical Expenses	N/A	-\$250
Taxable Gross	\$2,000	\$1,750
Taxes (Federal & State @ 20%)	-\$400	-\$350
Less Estimated FICA (7.65%)	-\$153	-\$133
Medical Deductions	-\$250	N/A
Take Home Pay	\$1,197	\$1,267

That's a
difference
of \$70!

Where allowable by law. If you are subject to FICA taxes, there might be a reduction in your social security benefit due to the reduction of FICA contributions. Example is hypothetical for illustrative purposes only. Please consult your tax advisor for actual tax savings.

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Help Save for Medical Expenses



Are you looking for a way to reduce your taxable income and help pay for medical and dependent care expenses? Reimbursement accounts can do just that.

With these accounts, you'll enjoy a money-saving way to pay for eligible medical or dependent care expenses with pre-tax dollars from your paycheck.

Just choose the amount to be deducted, and the funds are set aside to be used for expenses throughout the year. It's that easy.

Here's How They Work

A **Dependent Care Account (DCA)** allows you to set aside pre-tax dollars to reimburse yourself for eligible dependent care expenses. Because your money goes into the account before income tax is withheld, you pay less in tax and have more disposable income. You may allocate up to \$5,000 per tax year for reimbursement of eligible dependent care services (or \$2,500 if you are married and file a separate tax return).

A **Healthcare Flexible Spending Account (HCFSA)** can save you money by allowing you to set aside part of your pay, on a pre-tax basis, to reimburse yourself for eligible medical expenses such as copayments, deductibles, prescriptions, and more. The maximum amount allowed to contribute into this account is \$2,700 per calendar year. (Please see your employer for the maximum amount allowed by your plan.)

Fast, Easy Reimbursements

If you're interested in either of these accounts, we're happy to set up your account for direct deposit. You can either have your reimbursements deposited straight into your bank account or receive a check by mail – it's entirely up to you.

If you don't file sufficient claims for reimbursement, you could lose the unused amount remaining in your account at the end of the plan year. This is often referred to as the "use-or-lose" rule.

Your employer may offer a carryover of up to \$500 each plan year or a grace period, which is a period of time after the plan year ends where you may incur expenses and be reimbursed from the remaining balance in your previous year's account.

Examples of Eligible Expenses

Acupuncture	Invitro fertilization	Physical therapy provided by licensed therapist
Alcohol/drug rehab	Laser eye surgery	Practical nurse
Anesthetist	Midwife	Psychiatrist
Artificial limbs/teeth	Optometrist	Psychologist
Chiropractor	Orthodontia*	Stop-smoking program
Dental care	Out-patient care	Transportation expenses relative to medical care based on IRS standard mileage allowance
Eye exam/eyeglasses/contact lenses	OTC drugs and medicines for treatment of a medical condition**	Weight loss program for obesity***
Hearing aids/batteries	Pediatrician	
Insulin		

Examples of Ineligible Expenses

- Capital expenditures
- Cosmetic procedures
- Exercise equipment
- Insurance premiums
- Mattresses/pillows
- Personal use items
- Teeth whitening

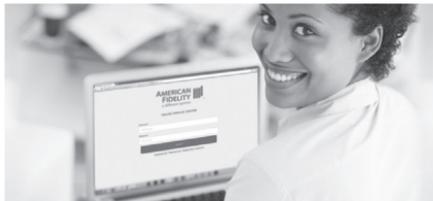
*Service must have been incurred or already paid.

**Will require a medical practitioner's prescription.

***May need doctor's statement for medical necessity.

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File a Claim Online



If you're looking for a way to receive your reimbursements quicker, filing a claim with American Fidelity has never been easier.

For faster reimbursement time, file online with an online account or one of our mobile apps. You may also download a claim form to submit by mail or fax. Sign up for direct deposit to help expedite your payment even more!

Here's How It Works

American Fidelity's online accounts and mobile apps give you quick, easy access to your insurance benefits and/or Flexible Spending Account (FSA) information. Visit americanfidelity.com to learn more.

If you don't already have an account, create one today at americanfidelity.com.

Features

- Review claim history, check claim status, and view account balances.
- Access detailed policy information.
- Submit reimbursement account and insurance benefit claims.
- Sign up for direct deposit.
- Submit documentation for Benefits Debit Card swipes.
- Access the most up-to-date plan certificate.

Accident Only Insurance



Accidents are inevitable. Even though you can't always prepare for unforeseen events, you can plan ahead. A **Limited Benefit Accident Only Insurance** plan may help ease the impact on your finances.

American Fidelity's Accident Only Insurance is designed to help cover some of the expenses that can result from a covered accident, and benefit payments are made directly to you.

Here's How It Works

This plan provides 24-hour coverage for accidents that occur both on and off the job and can help offset your medical expenses. There are over 30 plan benefits available, and coverage may also extend to your family.

Features

- Choose the coverage option that best fits your lifestyle and financial needs.
- Apply with no medical questions asked.
- The plan pays an annual Wellness Benefit for one Covered Person to receive a routine physical exam, including immunizations and preventive testing.
- The plan pays a benefit when an Accidental Death or Dismemberment occurs within 90 days of a covered accident.
- Policy is guaranteed renewable for as long as premiums are paid as required.
- You own the policy, so you can take it with you if you change jobs.

Limitations, exclusions, and waiting periods may apply. Not all products and benefits may be available in all states. This product is inappropriate for people who are eligible for Medicaid coverage.

Cancer Insurance



If you were unexpectedly faced with a cancer diagnosis, will your major medical insurance be enough? Even with a good plan, the out-of-pocket costs of treatment, such as travel, child care, and loss of income, can be expensive. American Fidelity's **Limited Benefit Cancer Insurance** may help.

Here's How It Works

If cancer touches someone in your family, this plan may help ease the impact on your finances. Benefit payments are made directly to you, allowing you to pay for expenses like copayments, hospital stays, and house and car payments.

Features

- Benefit payments made directly to you, so you can use your benefit for any expense you wish.
- Choose the coverage option that best fits your lifestyle and financial needs.
- More than 25 plan benefits available for cancer treatment, including wellness and early detection.
- Radiation, chemo, and hormone therapy.
- Covers transportation and lodging.
- You own the policy, so you can take it with you if you change jobs.

Not all riders may be available in every state. Limitations, exclusions, and waiting periods may apply. This product is inappropriate for people who are eligible for Medicaid coverage.

SB-30430-0716

Group Critical Illness Insurance



Although your traditional medical insurance may help pay for expenses directly associated with a critical illness, how will you cover indirect expenses?

American Fidelity's **Limited Benefit Group Critical Illness Insurance** can assist with the expenses that may not be covered by major medical insurance, allowing you and your family to focus on what matters the most – your recovery.

Here's How It Works

If you experience an event such as a heart attack or stroke, Critical Illness Insurance may help. It pays a lump sum amount to help with expenses that may not be covered by major medical insurance – house payments, everyday expenses, lost income, and more.

Features

- Receive an annual benefit for one covered health screening test per year, such as a stress test, echo cardiogram, blood glucose testing, or up to five other routine tests.
- Choose from three coverage amount options, \$10,000, \$20,000, or \$30,000, at the time of application.
- Benefits are paid directly to you, so you can use your benefit for any expense you wish.

Only offered on an after-tax-basis. Limitations, exclusions, and waiting periods may apply. This product is not available under Section 125 Plans. This product is inappropriate for people who are eligible for Medicaid coverage.

SB-30431-0716

Term Life Insurance



Life Insurance is an important piece of a strong financial plan. While there is no complete replacement for the loss of a loved one, American Fidelity's Term Life Insurance can help protect your family in your absence.

It provides short-term coverage at a competitive price. For those on a limited budget, Term Life Insurance can help fill temporary needs.

Here's How It Works

A Term Life Insurance policy may help supplement your existing coverage and may assist in meeting financial demands, should you need it. Plus, this is an individual policy, which means you own it and can take it with you to a different job or in retirement.

Features

- Choose from a 10, 20, or 30 year term period, based on your specific needs.
- Death benefit coverage starts as soon as you sign the application.*
- You own the policy, so you can take it with you to a different job or in retirement.
- The death benefit amount is generally paid tax free.

*Interim coverage for death will be in force from the date your application is signed if on such date the proposed insured is insurable per our underwriting guidelines for the requested coverage in accordance with the terms of the policy. This interim coverage for death will remain in force until the earlier of: 1) the date a policy becomes effective; 2) the date we decline the application; or 3) the date we notify the proposed insured that they are ineligible for interim coverage. The employee and/or spouse must remain actively at work during the interim coverage period. If the death of the proposed insured occurs during the interim coverage period, the first month's premium will be subtracted from the policy proceeds. Interim coverage is only for death benefits under the base policy, Children's Term Rider and Spouse Term Rider. No interim coverage benefits are available under any Waiver of Premium Rider, Accidental Death and Dismemberment Rider, or Accelerated Benefit Rider for Long Term Illness.

Rates are adjusted upon renewal. Please consult your tax advisor for your specific situation. Limitations, exclusions, and waiting periods may apply. Not generally qualified benefits under Section 125 Plans.

SB-30439-1217

Whole Life Insurance



It's important to prepare for the unexpected and help ensure your loved ones will be financially protected in the event of a tragedy. Your life insurance benefit can help replace your income and help your family meet important financial needs like funeral expenses, everyday living costs, and college.

Here's How It Works

American Fidelity's Whole Life Insurance provides protection for your entire life. American Fidelity's Whole Life Insurance provides protection for your entire life to age 121.

Features

- You own the policy, so you can take it with you to a different job or in retirement.
- Rates based on issue age and guaranteed not to increase during the life of the policy.
- Multiple coverage options available for you, your spouse, children, and grandchildren.
- Provides full cash value flexibility, including the ability to access cash or stop paying premiums and maintain some coverage.

Provided premiums are paid as defined in the policy. Limitations, exclusions, and waiting periods may apply. Not generally qualified benefits under Section 125 Plans.

60 SB-30510-1217

Prepare for Your Enrollment

You have a busy schedule, and your time is important. That's why we offer several ways to educate you on the benefits your employer has chosen so you may decide how well they serve the needs of you and your family.

Important Items to Consider

- Figure an estimate of out-of-pocket medical expenses. A worksheet is available on our website to help calculate these costs.
- Figure an estimate of child care expenses.
- Review your beneficiaries.
- Review all available benefit options, including portable insurance plans that you may keep, even if you change jobs.
- Evaluate your need for life insurance.

What You Need

- Driver's license
- Bank account information (if signing up for direct deposit)
- Spouse and children's DOB and Social Security Number, if considering coverage.
- Beneficiary information, including (if a trust) full name and date of trust.

Your Review Is Important

Before you decide on whether or not to attend a benefit review, think about some important questions. These will help you get the most out of your appointment time and ensure you and your family are protected.

- Have you recently received a pay increase?
- Have you or are you planning on getting married, having children, or buying a home?
- What would happen if you were suddenly ill or disabled?
- Are you preparing for life after retirement?

Remember: Benefits are designed to help protect you and your family from any unexpected moments or changes in life. Evaluate your available benefits to ensure you and your family are covered.

Dedicated Resources for You



Your local representative is available year-round for any questions you may have about our benefits and services.



Visit our website to file a claim, make changes to your account, or find a quick answer regarding your coverage.

americanfidelity.com



Enjoy the convenience of AFmobile®, our mobile app, for easy claim filing.

Download the app or visit secured.americanfidelity.com to create an Online Service Center account today.



Contact our dedicated customer advocate team Monday through Friday, 7am to 7pm CST.

800-662-1113



Eddie Arias
Account Manager
CA License Insurance #0M36894
9000 Cameron Parkway
Oklahoma City, OK 73114
800-654-8489 , Ext. 2447
americanfidelity.com

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WHY SAVE NOW?

Saving to your 457 deferred compensation plan has two key advantages:

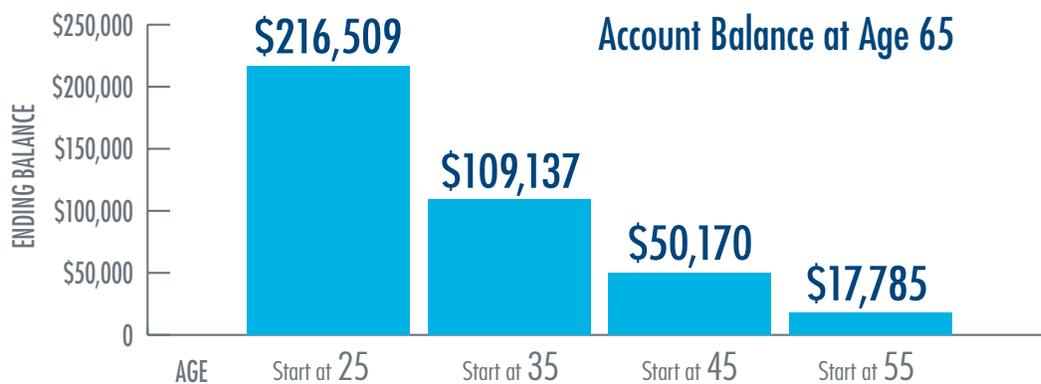


1 Convenient contributions — made directly from your paycheck.



2 Tax benefits — pre-tax contributions reduce your current taxable income, and all taxes, including on earnings, are deferred until you withdraw.

Saving early matters



For illustrative purposes only. Actual returns may be higher or lower. Assumes \$50 bi-weekly contributions and effective 6% average annual return, compounded biweekly.

- ▶ **See how delaying saving can cost you** — www.icmarc.org/costofdelay
- ▶ **Guided Pathways[®] helps you decide how much to save and how to invest** — www.icmarc.org/guidedpathways

Your ICMA-RC representative can help.

Joanne Holan
jholan@icmarc.org
877-313-8317

AC: 27527-0616-8380



BUILDING PUBLIC SECTOR
RETIREMENT SECURITY

ICMA RETIREMENT CORPORATION | 777 NORTH CAPITOL STREET, NE | WASHINGTON, DC 20002-4240
TEL: 202-962-4600 | FAX: 202-962-4601 | TOLL FREE: 800-669-7400 | WWW.ICMARC.ORG

GET TO KNOW YOUR 457 PLAN

Your pension and Social Security may go far, but you will likely need more income for a truly comfortable future. That's where your 457 deferred compensation plan comes in — see why it matters to you!

1 It's easy to contribute

- ▶ Make automatic paycheck contributions.
- ▶ Change your contributions any time.

2 Get tax benefits along the way

- ▶ Pre-tax contributions lower your tax bill, lessening the impact to your take-home pay.
- ▶ Delay all taxes, until you take money out.

3 A wide range of investments are available

- ▶ You control investment decisions, choosing from available options.
- ▶ Consider a diversified target-date fund or build your own portfolio. Get help with Guided Pathways® — www.icmarc.org/guidedpathways.

4 Take out what you need

- ▶ You control withdrawals upon separation from service with your employer.*
- ▶ Only 457 plans have no early withdrawal penalty regardless of your age.**

* Depending on your plan's rules, withdrawal and loan options may be available while you're still working.

** The penalty may apply to non-457 plan assets rolled into a 457 plan and subsequently withdrawn prior to age 59½.

HOW MUCH CAN I CONTRIBUTE?

For 2019, you can save as much as:

- ▶ \$19,000
- ▶ \$25,000 if age 50 or over
- ▶ \$38,000 if you qualify for pre-retirement catch-up contributions.

Reminder: you may be able to contribute accrued sick or vacation leave.

Can't save that much? Even small savings can really add up — start with as little as \$10 per paycheck.

The sooner you save, the more your money can grow — see how at www.icmarc.org/costofdelay.

Already enrolled? Aim to save more — see how at www.icmarc.org/savingsboost.

GET HELP ONLINE

- ▶ Manage your account — www.icmarc.org/login
- ▶ Tips and tools to help you save, invest, and retire — www.icmarc.org/education

Your ICMA-RC representative can help.

Joanne Holan
jholan@icmarc.org
877-313-8317

AC: 40436-1218-8571-W1394



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RETIREMENT SECURITY

ICMA RETIREMENT CORPORATION | 777 NORTH CAPITOL STREET, NE | WASHINGTON, DC 20002-4240
TEL: 202-962-4600 | FAX: 202-962-4601 | TOLL FREE: 800-669-7400 | WWW.ICMARC.ORG



Meet Your ICMA-RC Representatives



What questions do you have about your retirement accounts and financial goals?

Meet with your ICMA-RC representatives to help you plan, save, and invest.

Joanne Holan, your Retirement Plans Specialist, is your primary contact for retirement account questions, including enrollments, contributions, investments, and distributions.

James Collins, your CERTIFIED FINANCIAL PLANNER™, is available for broader and more complex discussions about your overall finances, including topics that impact your retirement security, such as credit and debt, insurance and estate planning, college funding, and tax and health care costs.

Reach out to Joanne and James:

	<p>Joanne Holan <i>Retirement Plans Specialist</i> 877-313-8317 jholan@icmarc.org</p>		<p>James Collins CERTIFIED FINANCIAL PLANNER™ 866-731-1051 jcollins@icmarc.org</p>
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ICMA-RC has a variety of tips, tools, and services to help you manage your retirement accounts – www.icmarc.org/realize.

Since 1972, our sole mission has been to help public sector employees build retirement security. *How can we help you?*

AC: 23712-0215-7635

Carrier Contact Information

Benefit	Carrier	Phone Number	Website
Medical	CalPERS	(888) 225-7377	www.calpers.ca.gov CalPERS > Active Members > Health Benefits > Eligibility & Enrollment > Open Enrollment
Dental	Delta Dental	HMO: (800) 422-4234 PPO: (800) 765-6003	www.deltadentalins.com
Vision	Vision Service Plan	(800) 877-7195	www.vsp.com
Life and AD&D and Disability	Cigna	(800) 362-4462	www.cigna.com
Cigna Health Rewards®	Cigna	(800) 258-3312	www.cigna.com/rewards Password: savings
Identity Theft Services	Cigna	US: (888) 226-4567 Outside US: (202) 331-7635	www.cignaplussavings.com/support/IdentityTheftProgram
Will Preparation Program	Cigna	(800) 901-7534	www.cignaplussavings.com/support/WillPreparation
Employee Assistance Program	Magellan	(800) 523-5668	www.magellanascend.com
Flexible Spending Accounts	American Fidelity	(800) 662-1113, Option 3	www.americanfidelity.com
Voluntary Benefits	American Fidelity	(800) 662-1113, Option 4	www.americanfidelity.com
457 Deferred Compensation Plan	ICMA	(877) 313-8317	www.icmarc.org

Contact your Town of Los Gatos Human Resources Team at hr@losgatosca.gov or (408) 399-5739 for more information on any of the benefits outlined in this guide.

While every effort has been made to be as accurate as possible in developing the enclosed information, the official plan documents prevail in all cases. This is not a legal document. It is a brief summary of benefits and is not considered "Evidence of Coverage." Please refer to the policy/plan documents for a complete description of the controlling terms, coverages, exclusions, limitations and conditions of coverage. In case of any discrepancy between this information and the policy/plan documents, the policy/plan documents will prevail.

Town of Los Gatos reserves the right to terminate, suspend, withdraw, or modify the benefits described in the policy/plan documents in whole or in part, at any time. No statement in this or any other document, and no oral representation should be construed as a waiver of this right. This summary is the confidential property of Town of Los Gatos.

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS ACT DISCLOSURE - FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

PATIENT PROTECTION MODEL DISCLOSURE

CalPERS HMO plans require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, CalPERS designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, go to the CalPERS website, www.calpers.ca.gov.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from CalPERS or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, go to the CalPERS website, www.calpers.ca.gov.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Town of Los Gatos Human Resources
110 E. Main St.
Los Gatos, CA 95032-6999
408-399-5739
HR@losgatosca.gov

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

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.

- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.
Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone’s health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers’ compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, and we will mail a copy to you.

If you have any questions about this Notice or about our privacy practices, please contact Human Resources at (408) 399-5739 or 110 E. Main St., Los Gatos, CA 95032.

Important Notice from Town of Los Gatos About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Town of Los Gatos and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Town of Los Gatos has determined that the prescription drug coverage offered by CalPERS is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Town of Los Gatos coverage may or may not be affected.

If you do decide to join a Medicare drug plan and drop your current Town of Los Gatos coverage, be aware that you and your dependents may or may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Town of Los Gatos and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Town of Los Gatos changes. You also may request a copy of this notice at any time. **For More**

Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2020
Name of Entity/Sender:	Town of Los Gatos
Contact--Position/Office:	Human Resources
Address:	110 E. Main St. Los Gatos, CA 95032
Phone Number:	(408) 399-5739



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Town of Los Gatos	4. Employer Identification Number (EIN) 94-6001435	
5. Employer address 110 E. Main St.	6. Employer phone number (408) 399-5739	
7. City Los Gatos	8. State CA	9. ZIP code 95032
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	12. Email address HR@losgatosca.gov	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
- All employees. Eligible employees are:
Regular Full-Time Employees

- Some employees. Eligible employees are:

- With respect to dependents:

- We do offer coverage. Eligible dependents are:
Legal Spouse, Domestic Partner, and Dependent Children to age 26

- We do not offer coverage.

- If checked, this coverage meets the minimum value standard*, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

* An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)