Employee Benefits Handbook

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SECTION 1: MEMORANDUM PRIVACY NOTICE APRIL 2019

CITY OF SAN JOSE
CAPITAL OF SILICON VALLEY

Memorandum

TO: All Employees **FROM: Human Resources**

SUBJECT: PRIVACY NOTICE **DATE: April 5, 2019**
EFFECTIVE APRIL 14, 2003
REVISED MARCH 19, 2004,
2nd REVISION OCTOBER 1, 2008
3rd REVISION SEPTEMBER 23, 2013
4th REVISION APRIL 5, 2019

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.

The City of San José (City) sponsors the following self-insured plans and programs ("Plans") that provide group health benefits:

- Blue Shield PPO
- Delta Dental PPO Plan
- Flexible Spending Accounts
- Employee Assistance Program

The Plans are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your Protected Health Information (PHI), to provide you with this notice of its privacy practices and legal duties with respect to PHI, and to notify you following a breach of your unsecured PHI. The Plans are required to abide by the terms of this notice. The Plans reserve the right to change the terms of this notice and to make any new provisions effective for all PHI that it maintains about you. Revised notices will be provided to you by mail within sixty (60) days. This notice does not address the health information policies or practices of your health care providers.

The Plans use administrative, technical and physical safeguards to ensure your PHI is treated in accordance with its privacy policy. The Plans also restrict access to this information to those employees who need the information in order to administer the Plans.

PROTECTED HEALTH INFORMATION

PHI is any individually identifiable health information related to the Plans that is created, transmitted, received or maintained by the Plans as necessary to administer these Plans and provide you with health care benefits. PHI includes hard copy information or information contained in electronic media format (e-PHI) whether in a storage device or in transit. Information is considered individually identifiable if an individual can be identified using the information alone or in combination. Examples of PHI include, but are not limited to:

- Your name

- Social Security number / member ID
- Demographic information (such as gender and date of birth)
- Genetic Information

PERMISSIBLE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The Plans are permitted to release or use your PHI for (1) specific administrative functions, (2) disclosures that you authorize in writing, (3) disclosures to you in accordance with your HIPAA rights, and/or (4) disclosures made for legal or public policy reasons. The Plans may only disclose the minimum PHI that is necessary to achieve the purpose of the use or disclosure. The following information outlines each of these permissible disclosures:

(1) Specific Administrative Functions – There are three specific administrative functions where disclosure of your PHI may be necessary for business reasons:

Health Care Operations – The Plans may use or disclose PHI to administer benefits and as necessary to provide coverage and services to you. Health Care Operations include such activities as:

- Customer service and resolution of complaints;
- Activities relating to creating or renewing insurance contracts; and
- Enrollment information

PHI may be disclosed to designated City personnel solely to carry out Plans-related administrative functions. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law.

Health Care Payment - The Plans may use or disclose PHI in order to pay for your covered health expenses such as making payments to other parties, including a health plan or provider.

Treatment – The Plans may use or disclose your PHI to determine eligibility for services or to provide you with information regarding health-related benefits and services.

(2) Self-Authorized Disclosures – You may authorize the Plans to disclose PHI information for a variety of reasons. For example, the Plans must obtain authorization to use or disclose psychotherapy notes in most circumstances, to use PHI for marketing purposes in most circumstances, to sell PHI, or to use or disclose PHI for any purpose not described in this notice. Such disclosure must be in writing and signed. You may revoke any self-disclosure authorization, in writing, at any time.

(3) HIPAA Rights Disclosures – HIPAA requires certain disclosures of PHI, as afforded under individual rights. Information regarding your HIPAA rights is outlined later in this notice.

(4) Legal or Public Policy Disclosures – The Plans may be required to disclose PHI to others when:

- Required by federal, state or local law
- Soliciting premium bids from other plans
- Required by court actions or law enforcement purposes, or
- Complying with laws related to workers' compensation

YOUR HIPAA RIGHTS REGARDING PHI

HIPAA privacy rules provide employees, retirees, and dependents with specific rights relating to PHI. The following information outlines these individual rights:

- Right to request to receive confidential communications by alternative means or at alternative locations if disclosure of PHI could endanger the individual.
- Right to review and obtain a hard copy of your PHI, or an electronic copy of PHI contained in electronic health records. A fee may be charged for producing and mailing your requested information, if applicable.
- Right to request that another person receive a copy of your PHI.
- Right to request an amendment to your PHI if you believe that information is incomplete or inaccurate. If your request is denied, the Plans will notify you in writing. Afterwards, you have the right to submit a written statement of disagreement and the Plans may then prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.
- Right to request restrictions on certain uses and disclosures of PHI. However, the Plans are not required to agree to a requested restriction unless disclosure is for payment or health care operations purposes and the PHI pertains to a health care item or service that has been paid in full by the individual.
- Right to request an accounting of certain disclosures of your PHI over the past six years.
- Right to request to receive communications in a certain way or at a certain location (e.g. a designated mail or e-mail address or phone number).
- Right to PHI use and disclosure protections after death. If an authorization for disclosure is required after your death, it must be obtained from a personal representative.
- Although authorization is not needed to disclose proof of immunization to a school when legally required for admission, authorization must be received from the adult student, parent or guardian of a child or other person acting on the student's behalf.

Copy of Privacy Notice – You have the right to get a copy of this notice by e-mail. A copy of this Privacy Notice is also posted on the City's Intranet site under HR Connection, then Employee Benefits, and then Resources.

Complaints – Any acquisition, access, use or disclosure of PHI in an impermissible manner that compromises the security or privacy of the PHI is presumed to be a breach of HIPAA. Notice of a breach to affected individuals must be provided no later than 60 days after discovery of the breach.

If you believe that your privacy rights have been violated, you may submit a written complaint (using the Health Information Privacy Complaint form posted on the City's Intranet site under HR Connection, then Employee Benefits, and then Resources) to: Privacy Officer, City of San José, Human Resources, 200 E. Santa Clara St., 2nd Floor Tower, San Jose, CA 95113.

You may also file a written complaint to the Centralized Case Management Operations, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201, , email OCRComplaint@hhs.gov, or file an electronic complaint at www.hhs.gov/ocr/privacy/hipaa/complaints/index.html. You will not be retaliated against for filing a complaint.

Contact us – If you have questions about this notice or your PHI, contact Human Resources by e-mail at HRbenefits@sanjoseca.gov or by calling (408) 535-1285.

Effective 4/14/03, Last Rev. 4/5/19

SECTION 2: INTRODUCTION

The City of San José is pleased to provide employees with an extensive benefits program. It includes insurance programs and other health, financial, and professional benefits. These benefit programs are listed below and described in this handbook. Complete details on each individual benefit plan can be found in each insurance provider's Evidence of Coverage (EOC), Summary Plan Description (SPD), brochure, policy certificate, or contract that applies to each benefit. The written policy, plan, or contract must be consulted to determine the terms and conditions of coverage for each benefit plan. If there is a difference between this handbook and the official Plan Document, the Plan Document (which may include underlying contracts) will govern.

The benefits described in this handbook are applicable to full-time and part-time benefited employees unless otherwise noted. For more information, related to applicable benefits for non-management employees, please refer to your Memorandum of Agreement (MOA), which is the contract with your bargaining unit (union). For management employees, please refer to the Benefits & Compensation summary applicable to your classification. MOA and Benefits & Compensation summaries can be found on the Office of Employee Relations website. If there are any differences in the information contained in this handbook and the applicable MOA or Compensation summary, the MOA or Compensation summary supersedes. If you are unclear about whether a particular benefit applies to you, please contact Human Resources at (408) 535-1285, or by e-mail at HRBenefits@sanjoseca.gov, or the Office of Employee Relations at (408) 535-8150.

SECTION 3: ELIGIBILITY AND ENROLLMENT

Eligible Employee

Generally, full-time (35+ scheduled hours), and part-time benefited (20+ scheduled hours) employees are eligible for benefits described in this handbook unless otherwise noted in specific sections, the employee's MOA, Benefits & Compensation summaries, or plan documents. For a more detailed explanation of eligibility, refer to the above-mentioned plan documents available on the Office of Employee Relations website or the HR Benefits website.

Eligible Dependents

For most of the City's benefit plans, dependents are defined as your spouse, domestic partner, and unmarried children (including adopted children, guardianships, stepchildren, and children of your domestic partner). Parents and grandparents would not be considered eligible dependents. Grandchildren are not considered eligible dependents unless the employee can furnish proof of legal guardianship or adoption.

Medical, EAP, Dental HMO, and voluntary AD&D Plans

Spouse, domestic partner, and child dependents under the age of 26 are eligible for benefits as your dependents regardless of marital or full-time student status.

Other Plans

Spouse, domestic partner, and child dependents under the age of 24 are eligible for PPO dental and vision regardless of **marital and full-time student status**.

Totally disabled child dependents age 19 and older may be eligible for benefits provided that: (1) the disability occurred prior to reaching age 19, (2) the employee contacted his/her health care provider and follow their application procedure for a dependent's disabled status, and (3) proof of continuing disability and dependency has been submitted to Human Resources.

Domestic Partner Dependent

The City of San José recognizes two levels of Domestic Partnerships:

- Unmarried same-sex or opposite-sex partnerships meeting the criteria of domestic partnership as defined by the State of California or as indicated on the City of San José *Affidavit of Domestic Partnership*. Benefit eligibility for this Domestic Partner relationship is explained in the paragraph on "***Domestic Partner Benefits***" below.
- Same-sex marriages certified by other jurisdictions for benefits purposes. Benefit eligibility for this relationship is explained in the paragraph on "***Same-Sex Marriage***" below.

Domestic Partner Benefits - Domestic Partners and children of a domestic partner may be added within 30 days of the beginning of a domestic partnership or state registration, during Open Enrollment or within the first 30 days of an employee's date of hire or eligible mid-year qualifying life event. To enroll a domestic partner and/or children of a domestic partner, the employee and his/her partner must complete and submit an *Affidavit of Domestic Partnership* or submit a Certificate of Domestic Partnership issued by the State of California along with the appropriate benefit enrollment forms and dependent children verification documentation to

Employee Benefits via document upload in eWay, via email to HRBenefits@sanjoseca.gov or in-person at Human Resources offices located in City Hall Tower, 4th Floor.

Domestic Partner Imputed Income Tax - A pro-rated portion of the monthly health premium that is attributable to domestic partners is considered taxable imputed income by the IRS. Please refer to the City's *Affidavit of Domestic Partnership* form for a more complete description of this tax matter.

The *Affidavit of Domestic Partnership* and other forms are available on the Human Resources – Benefits website: https://www.sanjoseca.gov/your-government/departments-offices/human-resources/benefits

Same-Sex Marriage Benefits – The City of San José recognizes same-sex marriages certified by other jurisdictions for benefits purposes. Employees in a same-sex marriage can enroll their new spouse, and children of their new spouse, under their benefit plans within the first 30 days of marriage. Employees are required to submit the Life Event changes along with the appropriate proof of eligibility documentation as listed in the table under the Dependent Verification section below via eWay Life Events.

Dependent Verification

One-Time Dependent Eligibility Verification

If an employee gets married, has a child, adopts a child, or becomes a legal guardian of a child during his/her City employment, he/she should review current benefit enrollments immediately. To enroll a new dependent mid-year, an employee can log-in to eWay to submit a life event and proof of eligibility documentation to Employee Benefits within the first thirty (30) days following the date of the qualifying event. The following chart is an easy guide to which additional document must be submitted. Failure to submit appropriate documentation will result in the dependent's ineligibility for coverage.

Dependent	Documentation
Spouse	· Marriage Certificate*
Domestic Partners(DP)	· City Affidavit of Domestic Partnership **or** · Declaration of Partnership filed with the California Secretary of State
Natural Child(ren)	· Birth Certificate*
Step Child(ren) or Child(ren) of Domestic Partner	· Birth Certificate* **and** · Marriage Certificate* showing spouse as Parent **or** · Affidavit of Domestic Partnership showing DP as parent
Children Legally Adopted/Wards	· Court documentation (Must include presiding Judge Signature & Court Seal)
Totally Disabled Children	· Certification of Disability from Social Security **or** · Document of Disability from Physician if not SSA Certified

** If the birth or marriage certificate is in a language other than English, a certified translation by an approved translator, or recognized agency such as the US Citizenship and Immigration Services (USCIS) is required.*

If the marriage certificate or children's birth certificates are not immediately available, an employee may request a 30-day extension by completing a *Life Event Attestation Form* located on Human Resources' Benefits page within that initial 30 days. An employee may then submit the required documents as soon as they become available. Failure to provide the required documents within the 30-day extension period may result in disqualification of the employee's dependents and their removal from coverage.

Disabled Dependent Verification & Re-certification

The City defines a disabled dependent as an unmarried child (prior to turning 26 years old) that is:

- Dependent on the subscriber, spouse or domestic partner for support and maintenance
- Certified as disabled by a licensed medical physician
- Incapable of self-sustaining employment due to a physical or mental condition
- Qualifies as a dependent on the subscriber's federal income tax

Anthem Blue Cross Medical Plans:

New Disabled Dependent Enrollment

Newly eligible City employees requesting to add their disabled dependent to their City coverage must provide proof of six months of prior coverage for this dependent, complete a Disabled Dependent Certification Form, and return this form to Anthem.

Adding a Dependent Who Has Become Permanently Disabled

The subscriber will need to provide proof of six months of prior coverage, a Disabled Dependent Certification form within 30-days of the date the dependent became disabled.

Recertification of Disability Status at Age 26

The subscriber will need to complete a Disabled Dependent Certification form and based on the physician's response may need to apply for recertification in 1-2 years, unless deemed permanently disabled. The subscriber would receive a copy of the over-age dependent notification letter within 45 days before the dependent is scheduled to be terminated.

Kaiser Permanente Medical Plans:

New Disabled Dependent Enrollment (within 30-days of disability)

The subscriber would need to complete a *Coverage for Overage Dependent Application*. This application consists of two parts: Part A is completed by the subscriber and Part B is completed by a licensed medical physician. If the dependent is deemed as temporarily disabled, recertification (Both parts A and B) will need to be completed every 2 years.

Recertification of Disability Status at Age 26

If Kaiser has not received certification for a disabled dependent, 90 days prior to the dependent turning 26, Kaiser will mail a certification packet. If the dependent is certified as permanently disabled, they will not need to recertify when reaching the age of 26.

Beneficiary Designations

Many benefit programs, such as retirement plans, deferred compensation, life insurance and accidental death and dismemberment insurance, have survivorship or beneficiary clauses. Employees will be asked to designate beneficiaries by name and by Social Security number during their initial enrollment.

An employee should always review his/her dependent coverage and beneficiary designations soon after any major life change (marriage, divorce, birth, or death in the family). Beneficiary changes can be made at any time. Information on how to update your beneficiary(ies) is available on the HR Benefits website.

Enrollment Periods

It is important for employees to recognize their responsibilities for enrolling in benefits. The City makes the benefit programs available, but employees must enroll to receive coverage for themselves and eligible family members.

Benefits enrollment is managed online through eWay, the City's payroll and benefits portal. You can access eWay from work or home.

- Work: https://sjhp92sso.hosted.cherryroad.com/ (Single Sign On)
- Home:https://sjhpss.hosted.cherryroad.com/psp/sjhpss/ESS/HRMS/?cmd=login&languageCd=ENG&

New Hire/Newly Eligible

As a new or newly eligible for benefits employee (20+ scheduled hours), you have 30 days from the date of hire or promotional start date to elect benefits which will be effective on the first of the month following your election date, following the City's Payroll Calendar. Failure to make elections will result in being defaulted. An employee may be required to wait for the City's annual open enrollment period to enroll or may lose an opportunity for guaranteed coverage (some insurance policies require medical underwriting information for late applications). These limitations usually apply to new dependents as well. Our benefits plan year runs from January to December.

Default Enrollment

Health & Dental

If a full time newly benefited employee (35+ scheduled hours) does not actively enroll in one of the City's Health or Dental plan options within the 30-day time limit, he/she will be enrolled by default in the Anthem $1500 Select HMO health plan and DeltaCare HMO dental plan employee-only coverage. Dependents will not be enrolled. Deduction for the employee's portion for said coverage will be reflected in the paycheck. Employees may not change health or dental plan elections, nor enroll any eligible dependents until the next open enrollment period. Open Enrollment changes will become effective January 1 of the following year.

EAP & Basic Life Insurance

Benefited employees (35+ scheduled hours) will be automatically enrolled in the Employee Assistance Program (EAP) and for Basic Life Insurance coverage when they become eligible for these benefits. Benefited employees who do not want to EAP coverage must waive this benefit by logging into eWay,

the City's benefits portal, to forego default enrollment. These benefits are 100% City-paid.
Please note that dependents are not automatically enrolled in the EAP. If an employee intends to enroll a dependent onto their EAP coverage after their first 30-days following their new hire enrollment/promotional event, they will need to wait until the Open Enrollment period.

Open Enrollment

As a benefits-eligible employee (20+ scheduled hours), you can enroll in or make changes to your benefit plans during the annual open enrollment period. At that time, you may change medical, dental, or vision plan providers, add eligible dependents and enroll in the City's pre-tax Flexible Spending Accounts(FSA); Medical Reimbursement and/or Dependent Care accounts for the following calendar year. Open enrollment is usually held beginning at the end of October through the second week of November, with changes effective January 1st of the following year.

Qualifying Life Events

Other than during the annual open enrollment period, IRS regulations state that you may not change your pre-tax benefit options unless you experience a qualifying event. Qualifying events include but are not limited to:

- **Change in legal marital status:** marriage, divorce, legal separation, annulment, registration or dissolution of domestic partnership, and death of a spouse
- **Change in number of dependents:** birth, adoption, placement for adoption, or death of a dependent child
- **Change in employment status:** the start or termination of employment by you, your spouse, or your dependent child
- **Permanent change in work schedule:** a significant increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full- time employment that affects eligibility for benefits
- **Change in a child's dependent status:** either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- **Change in your health coverage or your spouse's coverage attributable to your spouse's employment**
- **Change in an individual's eligibility for Medicare or Medicaid**
- **A court order:** resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child or dependent foster child
- **An event that is a special enrollment event under HIPAA (the Health Insurance Portability and Accountability Act):** acquisition of a new dependent or spouse or loss of coverage under another health insurance policy or plan if the coverage is terminated because of:
    - Voluntary or involuntary termination of employment or reduction in hours of employment or death, divorce, or legal separation.
    - Termination of employer contributions toward the other coverage, OR if the other coverage was COBRA Continuation Coverage, exhaustion of the coverage.

You must make the changes **within thirty (30) days of the date the event** (marriage, birth, etc.) occurs. Any changes you make must be consistent with the qualifying event. Failure to submit notification in a timely manner may impact dependent eligibility for health care continuation under COBRA and may result in you incurring liability for expenses for non-eligible dependents. Life event changes take effect the first of the

following month after they are processed in eWay. Life event submission requests may be made in eWay within 30 days of the event. For more information and examples of common life events and their requirements, please visit the Human Resources' Life Events web page.

SECTION 4: Premium Contributions

Benefit Cost

Because insurance premium rates change often, they are not included in this guide. An employee can obtain information about rates (premium costs) and regular contributions at any time by visiting the HR Benefits website. The City contributes to several benefits including Medical, Dental, Vision, Employee Assistance Program (EAP), and Life Insurance. The contribution level for these benefits is subject to each bargaining unit's Memorandum of Agreement (MOA) or Benefit and Compensation Summary. An employee should refer to his/her MOA or Benefit and Compensation Summary for cost sharing arrangements.

The percentage of the Medical and Dental plan premiums the City pays for an employee is based on his/her Standard Hours (the number of hours an employee is regularly scheduled to work each week). If an employee holds a benefited position, the City will pay the portion of health and dental insurance premiums shown below:

Standard Hours	Amount City Will Pay
Full-Time Employees & RWW Employees who work 35 - 39 Hrs	Based on MOA or Benefit and Compensation Summary
Part-Time Employees who work 30 - 39 Hrs & RWW Employees who work 30 - 34 Hrs	City pays 75% of its FT contribution
Part-Time & RWW Employees who work 25 - 29 Hrs	City pays 62.5% of its FT contribution
Part-Time & RWW Employees who work 20 - 24 Hrs	City pays 50% of its FT contribution

The City's contributions for other benefits may vary. Please consult the applicable union's Memorandum of Agreement (MOA) or Benefit and Compensation Summary for cost sharing information. Current premium rates are available on the HR Benefits website.

The following voluntary benefits are 100% employee-paid:

- Flexible Spending Accounts
- Additional Life Insurance
- Long Term Disability Insurance
- Personal Accident and Critical Illness Insurance
  Deferred Compensation

Pre-Tax Premiums

The City's medical, dental, vision, and flexible spending accounts plans are pre-tax benefits, which means premiums for these benefits are not subject to state or federal taxes. Premiums are paid before withholding taxes are calculated and deducted from the paycheck. Exempted from the pre-tax status are Health and Dental In-Lieu Plans. (Please refer to the *Affidavit of Domestic Partnership* form for information regarding exceptions to this taxation rule.)

Section 5: MEDICAL, DENTAL, AND VISION INSURANCE

The City of San José currently offers the following medical, dental and vision plans:

Medical Plans

- Anthem $20 Copay Traditional HMO
- Anthem $20 Copay Select HMO
- Anthem $1500 Deductible Select HMO
- Anthem $100 Deductible Select PPO
- Anthem $2500 Deductible Classic PPO w/ HSA
- Anthem $2500 Deductible Classic PPO w/o HSA
- Kaiser Permanente $25 Co-pay Health Maintenance Organization (HMO)
- Kaiser Permanente 1500 Deductible HMO
- Kaiser Permanente $3000 Deductible HMO with HSA
- Health-In-Lieu (available if you have other group medical insurance)
-

Dental Plans

- Delta Dental PPO Plan of California
- DeltaCare USA HMO
- Dental-in-Lieu Plan (available if you have other group dental insurance)

Vision Plans

- VSP Signature
- VSP Choice

A summary of each plan is presented in this handbook. Plan information and premium rates are available on the HR Benefits website.

When Coverage Begins

Medical plan premiums are paid on the first and second pay day of each month. After enrollment, an employee and his/her eligible dependents may use their selected medical plan starting on the first day of the month that has earnings for both pay days in that month. The employee can confirm the coverage start date by accessing their My Benefits Summary through eWay, a day after enrollment.

Coordination of Benefits

If an employee or his/her dependents are entitled to medical benefits under more than one medical, dental and/or vision plan, the employee should consult his/her respective plans to inquire about Coordination of Benefits. Sometimes one plan will pay a percentage of the cost not covered by another plan. Benefits are usually calculated so that the total payments by all plans involved will not be greater than the total cost of the covered services received. Employees should inform their doctors/providers about all plans under which they and their family are covered.

Note that DeltaCare will coordinate benefits only if a non-emergency service is provided through a DeltaCare dentist that has already been selected as the primary care dentist. The DeltaCare Prepaid Dental Plan makes no

payment toward dental work completed at any other location except in an emergency situation when DeltaCare may reimburse you up to $100 for covered procedures.

When Coverage Terminates

Medical, dental, and/or vision, and EAP coverage for the employee or his/her dependents will end on the last day of the month in which benefits eligibility or enrollment terminates. Continuation of coverage may be available. Refer to the section on COBRA Coverage for more information continuation of benefits for employees and their qualified dependents.

The last day of FMLA/CFRA and/or PDL time off work is the end of the protected period OR the date the employee informs his/her Department that he/she (i.e., the employee) will not be returning to work, whichever occurs first. Once FMLA /CFRA and/or PDL have been exhausted and the employee is unpaid, if the employee still cannot come back to work whether the employee is on ADA additional leave or not, coverage under the health plans will be terminated and employees on leave will be offered COBRA coverage due to the reduction of hours and the loss of coverage. An employee who does not return to employment with the City at the end of any protected time off work may have a right to select COBRA continuation coverage.

SECTION 6: MEDICAL PLAN OPTIONS

Choosing a Plan that is right for you and your dependents.

The differences between HMO and PPO plans include plan costs, the size of the plan network, ability to see specialists, and coverage for out-of-network services. Costs for HMO plans will be less, as premiums tend to be lower and there is no deductible. With an HMO you will need to select a primary care physician (PCP) and you will need a referral from the PCP if you want to see a specialist. Costs for PPO plans will be higher, as premiums tend to be higher and there is a deductible. However, PPOs are more flexible in that you do not need to select a PCP and no referral is needed to see a specialist.

HMO Plan Overview

A Health Maintenance Organization (HMO) plan gives you access to certain doctors and hospitals within its network. A network is made up of providers who have agreed to lower their rates for plan members and meet quality standards. But unlike PPO plans, care under an HMO plan is covered only if you see a provider within that HMO's network. There are also typically more restrictions for coverage than other plans, such as allowing only a certain number of visits, tests, or treatments. With an HMO plan, out-of-network coverage is limited to emergencies; non-emergency services are not covered.
Some other key points about HMOs:

- You will be required to select a primary care physician (PCP), who will determine what treatment you need and coordinate your care.
- You may need a PCP referral to be covered when you see a specialist or have a special test done.
- If you opt to see a doctor outside of an HMO network, there is no coverage, meaning you will have to pay the entire cost of medical services.

PPO Plan Overview

A Preferred Provider Organization (PPO) plan features a network of providers, and lets you see doctors both in and outside of the plan network, providing more flexibility when picking a doctor or hospital. Providers in the network agree to accept lower payments in exchange for access to patients. However, when you seek care from doctors outside of your plan network, you will usually pay more.
Here are some key features of a PPO:

- You can see a doctor or specialist without having to see a PCP first.
- You can see a doctor or go to a hospital outside the network and you may be covered. However, your benefits will be better if you stay in the PPO network.
- In-network providers offer lowest out-of-pocket costs; out-of-network providers have a higher cost.
- Premiums tend to be higher, and it's common for there to be a deductible.

Anthem Blue Cross $20 Co-pay Traditional HMO (Group #28297)

Anthem is a prepaid group practice health maintenance organization (HMO) that provides direct services only through Anthem hospitals, medical offices, and physicians. Anthem members must designate a personal physician from a list of available doctors otherwise, one will be automatically assigned to them. Most services and Prescriptions are covered with a co-payment. The Anthem $20 Copay Select HMO plan and Traditional HMO plans have the same plan design, however the Traditional Copay plan's network is larger and includes Palo Alto Medical Foundation (PAMF) and Silicon Valley Medical Network physicians, while the Select Copay's network does not include these medical groups. For more detailed information and rates, refer to the Summary of

Benefits and plan documents on the HR Benefits website.

Anthem Blue Cross $20 Co-pay Select HMO (Group #282397)

Anthem is a prepaid group practice health maintenance organization (HMO) that provides direct services only through Anthem hospitals, medical offices, and physicians. Anthem members must designate a personal physician from a list of available doctors otherwise, one will be automatically assigned to them. Most services and Prescriptions are covered with a co-payment. For more detailed information and rates, refer to the Summary of Benefits and plan documents on the HR Benefits website. New enrollees will receive a member card after enrollment. To contact Anthem's Customer Service Center, please refer to the Provider Contact Sheet.

Anthem Blue Cross $1500 Deductible Select HMO (Group #282397)

With this plan, members use the same Anthem facilities and network as the standard Anthem HMO plan. Anthem members must designate a personal physician from a list of available doctors otherwise, one will be automatically assigned to them. All your Preventative services are covered in full. You pay for the entire cost of non-preventative services until you satisfy your annual deductible of $1500 (employee only) or $3000 (employee + 1 or more). From that point, you pay a copay for office visits and coinsurance for non-preventative services until you reach your Calendar Year Maximum. For more detailed information and rates, refer to the Summary of Benefits and plan documents on the HR Benefits website.

Anthem Blue Cross $100 Deductible Select PPO (group # 282397)

The PPO plan was designed for employees or covered dependents that live outside of the designed medical plan Service Areas; however, any benefited employee is eligible to enroll. No primary care physician referrals are required. Services may be accessed directly through either Anthem's PPO network of participating physicians or facilities, or out-of-network altogether. Most services and Prescriptions are covered with a co-payment or coinsurance. Anthem's Select network is a narrow network of providers and facilities. For the Select PPO plan, Palo Alto Medical Foundation (PAMF) doctors are not included In-Network; however, they are available Out of Network. For more detailed information and rates, refer to the Summary of Benefits and plan documents on the HR Benefits website.

Anthem $100 Deductible Classic PPO (Group # 282397)

The Classic network is Anthem's largest network of providers and facilities and includes PAMF doctors In-Network. No primary care physician referrals are required. Services may be accessed directly through either Anthem's PPO network of participating physicians or facilities, or out-of-network altogether. Most services and Prescriptions are covered with a co-payment or coinsurance. For more detailed information and rates, refer to the Summary of Benefits and plan documents on the HR Benefits website.

Anthem $2500 Deductible Classic PPO with HSA (Group # 282397)

Services for this plan may be accessed directly through either Anthem's PPO network of participating physicians or facilities, or out-of-network altogether. The member pays for the entire cost of non-preventative services until he/she satisfies the annual deductible of $2500 (employee only) or $5000 (employee + 1 or more). From that point, member pays a coinsurance for office visits and coinsurance for non-preventative services until the Calendar Year Maximum is reached. The $2500 Anthem's HSA is offered through ActWise using PCN Bank. Employee Contributions are made with pre-tax dollars through payroll deductions and employees will be issued a debit card to pay for eligible expenses. There is currently no monthly maintenance fee nor minimum balance requirement associated with Anthem's HSA. For more detailed information and rates, refer to the Summary of Benefits and plan documents on the HR Benefits website.

What is a health savings account (HSA)?

An HSA is a financial account you can put money in to pay for health care services that are defined as qualified medical expenses as described in IRS Publication 502. You won't pay federal taxes on this money, and you can use it anytime to pay for care (consult with a qualified professional for tax, investment, or legal advice). Your account may earn interest, and you can take your money with you if you change jobs or retire. You may want to consult with a financial adviser for more information about HSA eligibility.

Who is eligible to set up an HSA?

To be eligible for HSA, you need to meet the following requirements:

- You must be enrolled in the Kaiser or Anthem HSA-qualified deductible health plan.
- You can't be enrolled in Medicare.
- You can't be eligible to be claimed as a dependent on someone else's tax return.
- You can't have additional health coverage that is not an HSA-qualified deductible plan. (There are certain exceptions, including specific injury insurance or coverage for accidents, disability, dental care, vision care, or long term care).

Kaiser PERMANENTE $25 Co-pay HMO (Group # 887)

Kaiser is a prepaid group practice health maintenance organization (HMO) that provides direct services only through Kaiser Foundation hospitals, medical offices, and physicians. Each Kaiser member is encouraged to choose a personal physician or Primary Care Provider (PCP) at a local Kaiser facility. Most services and Prescriptions are covered with a co-payment. For more detailed information and rates, refer to the Summary of Benefits and plan documents on the HR Benefits website.

Kaiser PERMANENTE 1500 Deductible HMO (Group # 887)

With this plan, members use the same Kaiser facilities and network as the standard Kaiser plan. All Preventative services are covered in full. The member pays for the entire cost of non-preventative services until he/she satisfies the annual deductible of $1500 (employee only) or $3000 (employee + 1 or more). From that point, member pays a copay for office visits and coinsurance for non-preventative services until the Calendar Year Maximum is reached. For more detailed information and rates, refer to the Summary of Benefits and plan documents on the HR Benefits website.

Kaiser PERMANENTE 3000 Deductible HMO with HSA (Group # 887)

With this plan, members use the same Kaiser facilities and network as the standard Kaiser plan. All Preventative services are covered in full. The member pays for the entire cost of non-preventative services until he/she satisfies the annual deductible of $3000 (employee only) or $6000 (employee + 1 or more). From that point, member pays a copay for office visits and coinsurance for non-preventative services until the Calendar Year Maximum is reached. For more detailed information and rates, refer to the Summary of Benefits and plan documents on the HR Benefits website.

Effective January 1, 2018, employees will have the opportunity to enroll in the Kaiser Health Savings Account (HSA)Qualified High Deductible HMO (DHMO) plan.

What is a health savings account (HSA)?

An HSA is a financial account you can put money in to pay for health care services that are defined as qualified medical expenses as described in IRS Publication 502. You won't pay federal taxes on this money, and you can use it anytime to pay for care (consult with a qualified professional for tax, investment, or legal advice). Your account may earn interest, and you can take your money with you if you change jobs or retire. You may want to consult with a financial adviser for more information about HSA eligibility. There is a monthly account administration fee of $3.25 per account, which may be automatically deducted from your HSA.

Who is eligible to set up an HSA?

To be eligible for HSA, you need to meet the following requirements:

- You must be enrolled in the Kaiser HSA-qualified deductible health plan.
- You can't be enrolled in Medicare.
- You can't be eligible to be claimed as a dependent on someone else's tax return.
- You can't have additional health coverage that is not an HSA-qualified deductible plan. (There are certain exceptions, including specific injury insurance or coverage for accidents, disability, dental care, vision care, or long term care).

Additional Information on Kaiser Permanente Plans

Employees must live or work in the Kaiser Service Area to enroll. Please contact Kaiser's Customer Service Center to confirm that you are currently living in a Kaiser Service Area. Some benefits, such as durable medical equipment, are not available to members who are not living in the Kaiser Service Area. Refer to the Evidence of Coverage document for more information.

New enrollees will receive a member card after enrollment. To contact Kaiser's Customer Service Center, please refer to the Provider Contact Sheet.

Health-in-Lieu Plan

The City of San José Health In-Lieu plan provides eligible employees a cash incentive to forego coverage under one of the City's available medical plans when employees can furnish proof of alternate group medical coverage. Participants who elect the Health In-Lieu plan receive a cash payment in-lieu of coverage.

In-Lieu Payments

Participants in the Health In-Lieu plan receive a cash payment in-lieu of coverage. Payments appear on each paycheck, 26 times per year; federal and state taxes are withheld on each payment. Health In-Lieu payment amounts are available on the on the HR Benefits website.

Enrollment in Health In-Lieu

Eligible employees may enroll online through eWay during their new hire/newly eligible enrollment or annual open enrollment period (typically held the last two weeks of October). Employees may enroll eligible dependents in Health In-Lieu for a greater benefit. The Plan and in-lieu payments are effective on the first day of the following calendar year. New employees have 30 days from their date of hire to enroll.

Employees may apply for Health In- Lieu during the year only if they become eligible due to a change in family status, and they must apply within 30 days of the date of that change and provide proof of alternate group coverage. A change in family status is defined as follows:

- Change in marital status – marriage, divorce, or legal separation
- Change in dependent status – birth, adoption, legal guardianship, or death
- Change in work status (either employee or employee's spouse) – termination of employment, commencement of employment, or change between part-time and full-time employment

Proof of alternate group coverage is a letter from the employer of an employee's spouse/domestic partner or covered person providing the alternate group coverage or other document such as a benefits confirmation statement, which confirms that the employee and dependents are enrolled in coverage through another employer's group health plan. Proof of alternate group coverage must identify the subscriber and list all covered dependents, the type of coverage, and the coverage effective date. The proof of coverage must be in effect for the current plan year. **Please note: Proof of individual coverage, such as Medicare, private, or state exchange, are NOT acceptable proof of alternate group coverage.**

Voluntary Cancellation

Employees who participate in the Health In-Lieu plan **may cancel** their participation and enroll in one of the available medical insurance plans **during open enrollment only unless they experience a qualified event (see details under "Enrollment Period")**. Cancellation will become effective with the first pay period of the following calendar year.

Mandatory Cancellation

If an employee enrolls in the Health In-Lieu plan and alternate coverage is lost prior to the next open enrollment period, the employee **must notify** Employee Benefits **immediately and not later than 30 days** from the date

coverage was lost. Upon receipt of documentation that coverage has been lost (from the providing employer or group insurer) an employee may enroll in any one of the City medical insurance plans, and may be responsible for paying back any Health In-Lieu payments received while no longer being eligible for the program.

Annual Alternate Group Medical Coverage Attestation

Employees enrolled in Health In-Lieu must submit an annual attestation of alternative group coverage in eWay. For each plan year, the Human Resources team will request that employees enrolled in Health In-Lieu complete an eWay form attesting that the employee and all other members of their family who are eligible for coverage under City sponsored healthcare have or will have minimum essential coverage. Employees who fail to attest to this may have their In-Lieu enrollment cancelled and medical coverage waived effective January 1st.

Excess In-Lieu Payments Received

If an employee cancels his/her Health In-Lieu plan and enrolls in an available medical insurance plan due to loss of alternate medical coverage, the City's policy is to make coverage in the medical plan effective the date the employee's alternate coverage is lost. Employee is responsible for repayment of any excess health-in-lieu payments/he or she may have received. Employee is also responsible for paying the employee portion of premiums necessary to begin City medical plan coverage following cessation of his/her other medical coverage.

SECTION 7: DENTAL PLAN OPTIONS

City of San José provides you with (2) affordable dental care plans through Delta Dental. Below is a Plan Comparison Chart.

	Delta Dental PPO Plan (Group #2584)	HMO Plan (Group #5643)
Can I go to any dentist?	Any licensed dentist but visiting an in-network dentist will be the most cost effective.	You must select a DeltaCare USA primary care dentist and visit this dentist to receive services.
What procedures are covered?	Exams and cleanings: 2 per year, covered at 100% at a PPO dentist and 85% at a Delta Dental Premier or non-Delta Dental dentist Fillings, extractions, sealants, root canals, gum treatment and oral surgery: Covered at 85% at any dentist Crowns, bridges, and dentures: Covered at 65% at a PPO dentist and 60% at a non-PPO dentist Orthodontics: Covered at 60% at any dentist for adults and children, up to $2,000 lifetime maximum per person (must be medically necessary)	**Exams, cleanings, sealants, fluoride treatment, root canals, extractions, gum treatment, oral surgery, dentures: No cost** **Filings:** $)-55 copayment, depending on materials, tooth and size of filing **Crowns and bridges:** $75-175 copayment, depending on materials **Orthodontics:** $1,000 copayment for comprehensive orthodontic treatment for adults and children. Includes medically and non-medically necessary orthodontia Coverage is limited to once per eligible member per lifetime
Are there deductibles and maximums?	No deductible – there is an annual maximum benefit of $2,100 per person when visiting a PPO dentist or $2,000 when visiting a non-PPO dentist	No, there are no annual deductibles or maximums
What happens if I need to see a specialist?	You do not need a referral from your dentist.	Contact your DeltaCare USA primary care dentist to coordinate the referral.
How do I change my dentist?	You can change your dentist at any time without contacting Delta Dental.	You can change your selected or assigned primary care dentist online or by telephone.

Delta Dental PPO (GROUP # 2584)

Delta Dental PPO of California is an indemnity dental plan. A covered member may go to any dentist and may change dentists at any time. Employees receive a better benefit by going to a dentist within Delta's PPO network of dentists.

For more detailed information and rates, refer to the Summary of Benefits and plan documents on the HR Benefits website.

Delta Dental does not send new enrollees a member card upon their initial enrollment; however, access to coverage is always available by providing the employee's name, social security number and the City's Delta Dental group number (2584) to the dentist upon request.

To contact Delta Dental's Customer Service Center, please refer to the Provider Contact Sheet.

DeltaCare® USA Dental HMO (GROUP #5643)

DeltaCare is a pre-paid dental health maintenance organization (DHMO) that provides direct services through its exclusive dentist network. An employee must select a primary care dentist from the list of DeltaCare providers when he/she enrolls in DeltaCare. A list of DeltaCare provides is available on Delta Dental's website at: http://www.deltadentalins.com.

For more detailed information and rates, refer to the Summary of Benefits and plan documents on the HR Benefits website.

New enrollees will receive a member card after enrollment. To contact DeltaCare's Customer Service Center, please refer to the Provider Contact Sheet.

Dental-in-Lieu Plan

The City of San José's Dental In-Lieu Plan provides eligible employees a cash incentive to forego coverage under one of the City's available dental plans when employees can furnish proof of alternate group coverage.

In-Lieu Payments

Participants in the Dental In-Lieu plan receive a cash payment in-lieu of coverage. Payments appear on each paycheck, 26 times per year; federal and state taxes are withheld on each payment. Dental In-Lieu payment amounts are available on the Benefits website.

In-Lieu Enrollment

Eligible employees may enroll online through eWay during their new hire/newly eligible enrollment or annual open enrollment period (typically held the last two weeks of October). The Plan and in-lieu payments are effective on the first day of the following calendar year. New employees have 30 days from their date of hire to enroll.

Employees may apply for Dental In- Lieu during the year only if they become eligible due to a change in family status, and they must apply within 30 days of the date of that change and provide proof of alternate group coverage. A change in family status is defined as follows:

• Change in marital status – marriage, divorce, or legal separation

• Change in dependent status – birth, adoption, legal guardianship, or death

• Change in work status (either employee or employee's spouse) – termination of employment, commencement of employment, or change between part-time and full-time employment

Proof of alternate group coverage is a letter from the employer of an employee's spouse/domestic partner or covered person providing the alternate group coverage or other document such as a benefits confirmation statement, which confirms that the employee and dependents are enrolled in coverage through another employer's group dental plan. Proof of alternate group coverage must identify the subscriber and list all covered dependents, the type of coverage, and the coverage effective date. The proof of coverage must be in effect for the current plan year. **Please note: Proof of individual coverage, such as Medicare, private, or state exchange, are NOT acceptable proof of alternate group coverage.**

Voluntary Cancellation

Employees who participate in the Dental-In-Lieu plan **may cancel** their participation and enroll in one of the available dental insurance plans **during open enrollment only unless they experience a qualified event (see details under "Enrollment Period")**. Cancellation will become effective with the first pay period of the following calendar year.

Mandatory Cancellation

If an employee enrolls in the Dental In-Lieu plan and alternate coverage is lost prior to the next open enrollment period, the employee **must notify** Employee Benefits **immediately and not later than 30 days** from the date coverage was lost. Upon receipt of documentation that coverage has been lost (from the providing employer or group insurer) an employee may enroll in any one of the City dental insurance plans, and if applicable may be responsible for paying back any Dental In-Lieu payments received while no longer being eligible for the program.

Annual Alternate Group Dental Coverage Attestation

Employees enrolled in Dental In-Lieu must submit annual attestaion of alternative group coverage. For each plan year, employees enrolled in Dental In-Lieu will need to complete an eform via eWay attesting that the employees and all other members of their family who are eligible for coverage under City sponsored healthcare have or will have minimum essential coverage. Employees who fail to attest to this may have their In-Lieu enrollment cancelled and dental coverage waived effective January 1st.

Excess In-Lieu Payments Received

If an employee cancels his/her Dental In-Lieu plan and enrolls in an available dental insurance plan due to loss of alternate dental coverage, the City's policy is to make coverage in the dental plan effective the date the employee's alternate coverage is lost. Employee is responsible for repayment of any excess dental-in-lieu payments/he or she may have received. Employee is also responsible for paying the employee portion of premiums necessary to begin City dental plan coverage following cessation of his/her other dental coverage.

SECTION 8: VISION PLAN OPTIONS

City of San José provides you with (2) affordable eye care plans through VSP. Below is a Plan Comparison Chart.

	Signature Plan (Group #12112926)	Choice Plan (Group #12112926)
Annual Vision Exam:	$10 Co-pay	$10 Co-pay
Eyeglass Lenses: **(Single vision & lined bi/trifocal lenses. More options are available with additional cost)**	Paid in full every year	Paid in full every year
Eyeglass Frames:	$170 featured frame brands allowance, Up to $150 frame allowance **every other calendar year** ($80 allowance for frames at Affiliate Providers, including Walmart/Sam's Club/Costco)	$170 featured frame brands allowance, Up to $150 frame allowance **every calendar year** ($80 allowance for frames at Affiliate Providers, including Walmart/Sam's Club/Costco)
Contact Lens Exam: **not to exceed $60**	15% off contact lens exam (fitting and evaluation)	15% off contact lens exam (fitting and evaluation)
Contact Lenses:	$105 allowance when selected instead of frames and lenses	$105 allowance when selected instead of frames and lenses

For more detailed information and rates, refer to the Summary of Benefits and plan documents on the HR Benefits website.

Accessing In-Network Services

Contact a participating VSP vision provider office. Give them the covered employee's name, date of birth, Social Security Number, and notify them that you have coverage under the City of San Jose's ***VSP SIGNATURE/CHOICE*** plan. The provider's office staff will verify eligibility with VSP and schedule an appointment.

Accessing Out-of-Network Services

Coverage is reduced for services accessed outside of the Vision Service Plan network of providers. Employees should contact VSP prior to accessing out-of-network services whenever possible to verify limitations or exclusions in coverage. Covered members are responsible for paying the provider in full at the time services are accessed. At that time, request an itemized receipt of products and services received. Then send this information along with a letter requesting reimbursement to:

Vision Service Plan
PO Box 997100
Sacramento, CA 95899-7100

Be sure to include the employee's Social Security Number, name, the City's group number, the patient's name, relationship to employee, date of birth, phone number, and address.

VSP Insurance Claims Complaint/Appeal Procedures

If a subscriber or enrollee (hereafter “enrollee”) has a complaint or grievance (hereafter “grievance”) regarding VSP service or claim payment, the enrollee may communicate the grievance to VSP by using a form which is available by calling VSP’s Customer Service Department’s toll-free number (1-800-877-7195) Monday through Friday, 6:00 a.m. to 7:00 p.m. (PST). Grievances may be filed in writing with VSP at 333 Quality Drive, Rancho Cordova, California 95670.

Upon receipt of a verbal or written grievance, VSP will respond in writing to the enrollee acknowledging receipt and/or disposition of the grievance within five (5) business days. VSP is generally responsible for resolving grievances within thirty (30) days from the date of receipt. VSP will keep all grievances and the responses thereto on file for seven years.

Section 9: EMPLOYEE ASSISTANCE PROGRAM (EAP)

The City's Employee Assistance Program (EAP) administered by CONCERN has been established to offer free, confidential counseling to benefited employees and their dependents (except Temporary Executive Managers and Temporary Unclassified Employees), and effective January 1, 2024, unbenefited part-time employees in the Municipal Employees' Federation (MEF) union. This benefit is 100% City-paid. All full- time and part-time benefited employees may enroll themselves and their eligible dependents. MEF unbenefited part-time employees are only eligible for this benefit. (excludes dependents)

Services cover a wide range of personal issues including:

- Managing stress
- Handling relationship issues
- Balancing work and life
- Quitting tobacco, alcohol, or drug use
- Caring for children or aging parents
- Exploring career development options
- Dealing with conflict or violence
- Working through grief and loss issues
- Controlling depression and anxiety
- Legal consultation
- Financial services consultation

For more detailed information, refer to the Summary of Benefits and plan documents on the HR Benefits website.

When Coverage Begins

Employees and their eligible dependents, if enrolled, may use the counseling or life management services on the first of the month following benefits enrollment.

Counseling Benefits

Experienced, licensed counselors are available in-person, via telephone, video, text, and/or chat.

Non-Sworn benefits (available for employees and eligible dependents)
- Up to 8 free sessions per person, per issue type, 12-month period.

MEF Unbenefited Part-time Employees (available for employees only)
- Up to 5 free sessions per person, per issue type, 12-month period.

Sworn Police and Fire and Safety Dispatcher benefits (available for employees and eligible dependents)
- Up to 20 free sessions per person, per incident, per 12-month period.

If additional appointments are necessary, employees must pay; however, employees may pay a reduced rate for additional counseling services. If an incident is exceptionally serious, your counselor may refer you or your dependent to your healthcare plan or recommend another agency in a special field of expertise. Referrals to your healthcare plan and recommendations to other agencies in a special field of expertise are not covered under the EAP; any cost would be paid by the employee.

If referred to EAP by your supervisor for a work-related problem, attendance is usually voluntary, but in some cases it may be mandatory. Refer to your MOA for specific information.

Life Management Benefits

Telephone consultations are available to employees and their eligible dependents for life management issues. Examples of life management consultation areas include Pre-Retirement Planning, Financial Planning, Child and Elder Care Referral, Taxpayer Consultations, and Legal Guidance (for questions regarding wills & contracts or questions related to family, real estate, personal injury, criminal and consumer law).

Telephone consultation sessions are usually limited from 30 to 60 minutes for each call per separate matter and there are unlimited follow-up telephonic sessions.

Accessing EAP Services

Contact CONCERN directly to schedule counseling or work and life services by calling (800) 344-4222 (available 24 hours a day) or visiting: https://login.concernhealth.com

If you are experiencing a medical or psychiatric emergency, please dial 911

Company Code	
For both Sworn & Non-Sworn	**sanjose**

Confidentiality Assurance

Visits to a counselor are completely confidential unless the participant undergoing counseling authorizes the release of information by signing a release form. If you encounter service issues with a CONCERN provider or facility and you are concerned about maintaining your privacy within the City, please refer to the EAP Service Complaints/Appeals section below.

EAP Service Complaint/Appeals Procedures

If you have a complaint or dispute about Concern's services or counselors, you may call the same toll-free number you use to access your EAP services, visit their website at GRIEVANCE FORM - Concern (concernhealth.com) to submit a complaint online, or submit a complaint in writing to:

Clinical Manager

CONCERN: Employee Assistance Program

2490 Hospital Drive, Suite 310

Mountain View, CA 94040

Within five business days of receiving your complaint, Concern will let you know, in writing, that your complaint was received, and they will submit it for resolution to the appropriate department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Plan, or a grievance that has remained unresolved for more than 30 days, you may call the California Department of Managed Health Care at (888) 466-2219. The hearing and speech impaired may use the California Relay Service's

toll-free telephone numbers: (800) 735-2929 (TTY) or (888) 877-5378 (TTY) to contact the DMHC. The DMHC's website (www.dmhc.ca.gov) also has complaint forms and instructions online.

When Coverage Terminates

EAP coverage will end on the last day of the month in which the employee's employment or benefits eligibility terminates. Dependents' coverage will end on the last day of the month in which either the employee or the employee's dependents are no longer eligible. Continuation of coverage may be available. Refer to the Employee Benefits Handbook, Section 12 COBRA Coverage for more information about Medical, Dental, Vision, EAP, or MRA benefits continuation for employees and their qualified dependents.

SECTION 10: FLEXIBLE SPENDING ACCOUNTS

The City of San José offers employees two flexible spending account (FSA) options, the Medical Reimbursement Account (MRA) and the Dependent Care Assistance Plan (DCAP) in accordance with IRS Sections 125 and 129. These plans offer employees the ability to save on taxes for qualified out-of-pocket healthcare and dependent care expenses. The current Plan Administrator is P&A Administrative Services, Inc. For more detailed information, refer to plan documents on the HR Benefits website.

New enrollees will receive a debit card after enrollment. Only 1 debit card will be issued to pay for MRA and DCAP expenses. To contact P&A's Customer Service Center, please refer to the Provider Contact Sheet.

Eligibility

All full-time and part-time benefited employees are eligible to participate in the MRA and DCAP programs.

To participate in DCAP employees must also meet the following eligibility rules:

- The employee must be at work while his/her child or other dependent is receiving care. If married, the employee's spouse must also be employed, or be a full-time student, or be disabled.
- Eligible children must be 12 or under. Other dependents (such as children age 13 or over, parents, or a spouse) are eligible only if they are disabled or cannot care for themselves because of physical or mental disability.
- The child, or other dependent, receiving care must live in the employee's home, and must be claimed as a dependent on the employee's federal income tax return.
- The employee must pay a "qualified person" to care for his/her eligible dependent at the employee's home, at a licensed day care center, or at another location. Any overnight camps or any schools for first grade or above are not qualified. A "qualified person" does not include any of your children under 19, or any other person whom the employee claims as a dependent.
- The employee must show the name, address, and taxpayer identification number of any persons or dependent care centers that he/she pays to provide dependent care on your federal income tax return.

Cost

There is a $2.50 employee-paid monthly administrative fee for participating in one or both of the City's Flexible Spending Accounts. This amount is subject to change at the beginning of each plan year.

How the Plan Works

With the assistance of the Plan Administrator or a tax advisor, the employee will need to estimate his/her annual out-of-pocket health and/or dependent care expenses. That amount is divided by 24 pay periods in a year and deducted from each paycheck semi-monthly before taxes are applied to the gross earnings. This reduces the amount of money on which the employee has to pay taxes.

After the money is deducted, it is banked in a tax-free reimbursement account.

Employees can track account balance information and file claims online at P&A Group's website. A paper claim form can also be downloaded from the HR Benefits website. Employees may request reimbursement biweekly,

monthly, or once a year; it is their choice. **Note that employees may only request reimbursement for expenses as they contribute to the DCAP account. Employees cannot receive reimbursement more than their year-to-date deposits in DCAP.**

The Plan Administrator will provide a monthly account statement. These statements should be read carefully to understand the amount remaining in the reimbursement account.

Please note: *Due to IRS regulations, employees enrolling in an FSA who earn $120,000 or more may be limited in their contribution amount elections. The contribution amount limit will be determined by testing during the plan year. I understand and agree that if my election is over the limit, the City will reduce my election in order for the plan to pass IRS testing.*

Tax Advantage Illustration

	Without MRA/DCAP	With MRA/DCAP
Annual Income	$ 51,000	$51,000
Annual MRA Election Amount	<$ 0>	<$ 1,000>
Taxable Income	**$51,000**	**$50,000**
Taxes Taken Out at 25%	<$ 12,750>	<$ 12,500>
Take-home Pay (after taxes)	**$ 38,250**	**$ 37,500**
Out-of-Pocket Expenses	<$ 1,000>	<$ 1,000>
Reimbursements (using pre-tax deductions)	$ 0	$ 1,000
Net Income	**$ 37, 250**	**$ 37, 500**
Annual Tax Savings*	**$ 250**	

* This example is for illustration purposes only. In no way should this example be used to calculate your actual tax savings. Please consult a qualified tax advisor for more information about how these pre-tax programs will benefit you, specifically.

Plan Options

Medical Reimbursement Account (MRA)

Normally, out-of-pocket healthcare expenses are paid with money that has already been taxed. However, using the MRA program, out-of-pocket expenses can be reimbursed from a trust account funded with pre-tax deductions from the employee's paycheck. This reduces taxable income so City employees will pay less in taxes and have more money to spend and save.

Reimbursable Expenses

The following are examples of expenses that qualify as 'reimbursable' under the MRA plan:

1. Insurance co-payments
2. Unreimbursed medical/dental expenses
3. Acupuncture, Chiropractic, Homeopathic Therapy, etc.
4. Contact lens solution
5. Laser eye surgery

6. Over the Counter (OTC) Medications
7. Menstrual care products

Please consult the FSA store eligibility list for a complete and current list of eligible expenses.

Dependent Care Assistance Program (DCAP)

Normally, dependent care is paid for with money that has already been taxed. However, using the DCAP program, out-of-pocket expenses can be reimbursed from a trust account funded with pre-tax deductions from the employee's paycheck. This reduces taxable income so City employees will pay less in taxes and have more money to spend and save.

Qualified Dependent Care

The following types of dependent care arrangements qualify for the DCAP plan:

- A dependent day care center where care is provided for more than six (6) individuals. The facility must comply with applicable state and local laws.
- An educational institution for pre-school children. For older children, only expenses for non-school care are eligible.
- An individual who provides care inside or outside your home. This person may not be the employee's child under 19, or anyone he/she claims as a dependent for Federal tax purposes.

"Use It or Lose It" Rule

At the time of enrollment, be sure to designate an annual amount that will cover only expenses that you know you will have during the plan year. If you do not spend all the money that you designated for the plan year, the remaining account balance is lost. It cannot be returned to you according to the IRS' "use it or lose it" rule.

Plan Year Grace Period

The IRS allows MRA participants to continue to incur expenses for 2 ½ months after the end of the plan year (March 15 of the year following the plan year), and until June 15 to submit for expenses incurred during the plan year.

When Coverage Terminates

The MRA and DCAP accounts closes at the end of each calendar year. Eligibility to participate prospectively in this pre-tax program will end either on the last day of the calendar year or on the last day employed or the last day on which the employee was eligible for the benefit. If the employee participated in a plan year and at some point separated from City service or ceased to be eligible, he/she may request reimbursements from the account retroactively only for the period in which he/she was an active participant. Continuation of coverage may be available. Refer to the Employee Benefits Handbook, Section 11 COBRA Coverage for more information about Medical, Dental, Vision, EAP, or MRA benefits continuation for employees and their qualified dependents.

SECTION 11: COBRA COVERAGE

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. When a loss of coverage occurs, the Consolidated Omnibus Budget Reconciliation Act (COBRA) provides that the same medical, dental, vision, Medical Reimbursement Account (MRA), and Employee Assistance Program (EAP) benefits be made available for employees, former employees, and dependents. The P&A Group is the City's COBRA Administrator.

For any questions about COBRA continuation, please contact Employee Benefits at (408) 535-1285 or HRBenefits@sanjoseca.gov. Additional information is also available on the HR Benefits website.

Qualifying Events for Employees

COBRA allows benefited employees (and any covered dependents) to continue medical, dental, vision, MRA, or EAP benefits at their own expense for up to thirty-six (36)* months after one of the following qualifying events occurs:

- Termination of employment (other than for gross misconduct).
- Loss of benefited status whether by reduction in work hours or change in job classification, or leave of absence due to a reduction in hours and/or loss of coverage.

Qualifying Events for Spouses/Domestic Partners/Children

COBRA allows covered dependents to continue medical, dental, vision, MRA, or EAP benefits at their own expense for thirty-six (36) * months after one of the following qualifying events occurs:

- Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct.
- Reduction in the hours worked by the covered employee.
- Covered employee's becoming entitled to Medicare.
- Divorce or legal separation of the covered employee.
- Death of the covered employee.
- Loss of dependent child status under the plan rules

**COBRA participants enrolled in the Dental plan and/or Vision plans are only eligible for (18) eighteen months of COBRA. MRA coverage is only continued through the end of the plan year in which the qualifying event occurs.*

Definition of Qualified Beneficiaries

A qualified beneficiary generally is an individual covered by a group health plan on the day before a qualifying event who is either an employee, the employee's spouse or domestic partner, or an employee's dependent child. In certain cases, a retired employee, the retired employee's spouse or domestic partner, and the retired employee's dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary. Agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

Eligibility Notifications

When the plan receives a notice of a qualifying event, the plan must give the qualified beneficiaries an election notice, which describes their rights to continuation coverage and how to make an election. The notice must be provided to the qualified beneficiaries within 14 days after the plan administrator receives the notice of a qualifying event. The election notice should contain all the information you will need to understand continuation coverage and make an informed decision whether or not to elect continuation coverage. It should also give you the name of the plan's COBRA administrator and tell you how to get more information.

Election Requirements

If coverage continuation under COBRA is desired, the employee or eligible dependent must notify the Plan Administrator within sixty (60) days after receiving the notification of the qualified beneficiaries' COBRA rights, or within sixty (60) days after losing coverage after a qualifying event, whichever is later.

The COBRA participant will then have forty-five (45) days to make the initial premium payment along with any subsequent premiums due for the months following the qualifying event. The cost to continue coverage under COBRA will be the total cost of the premium plus a minimal administrative fee which cannot legally exceed 2% above the premium cost for active employees.

Contact P&A Group, the administrator, at (800) 688-2611 or www.padmin.com for more information regarding election/enrollment administration and premium remittance.

Contact the City of San Jose Human Resources at (408) 535-1285 or HRBenefits@sanjoseca.gov for general benefit plan questions or questions on when you should expect to receive a COBRA Enrollment Kit.

When Coverage Terminates

Continued coverage under COBRA will terminate at the end of the month in which any of the following occur:

- The allowable number of months of continued coverage expires.
- Premiums are not paid as required.
- The COBRA participant becomes eligible for health benefits under another health plan or becomes eligible for Medicare benefits.

Once COBRA Coverage Terminates, It Cannot Be Reinstated.

SECTION 12: LIFE INSURANCE

All active full-time benefited employees are eligible to participate in the City's group term life insurance policy with Standard Insurance Company (part-time benefited and temporary employees are not eligible for life insurance). The City offers three kinds of life insurance benefits administered by Standard Life Insurance: Basic Life Insurance, Accidental Death, and Dismemberment (AD&D) and Additional Life Insurance. Basic Life and AD&D are benefits paid for by the City in an amount specified in the employee's MOA and for management employees, in the Benefits and Compensation Summary.

For more detailed information, including Certificate of Insurance and rates, visit the HR Benefits website.

To contact The Standard's Customer Service Center, please refer to the Provider Contact Sheet.

Plan Options

Basic Life Insurance and Accidental Death and Dismemberment (AD&D)

Eligible employees are automatically enrolled in City-paid Basic life insurance and AD&D. These benefits are 100% paid for by the City for a coverage amount specified in the employee's MOA and for management employees, in the Benefits and Compensation Summary.

Voluntary Life Insurance

An employee may also apply for Voluntary Life insurance for self, spouse/domestic partner, and/or child(ren). For this voluntary life insurance, the employee pays for 100% of the premium through semi-monthly post-tax payroll deductions. Premiums are based on age and level of coverage selected and will vary. Visit the Life Insurance webpage for more details and rates.

Plan 3 Additional Employee Life/AD&D Insurance

You may apply for coverage in increments of $10,000 up to a maximum $750,000 (not to exceed an amount equal to 6 times your annual earnings, rounded-up to the next multiple of $10,000). There is a guarantee issue amount of up to $200,000 if you apply within 31 days of employment or benefits eligibility. A Medical History Statement or application for coverage is required for enrollments outside of this period and the application will be subject to The Standard Insurance Company's underwriting review process.

If you are already insured for additional life, participants may increase current coverage an additional $20,000 without medical underwriting during Open Enrollment up to the $200,000 guarantee issue amount. If a member already has $200,000 of coverage, medical underwriting would be required for any increases.

Spouse/Domestic Partner Life/AD&D Insurance

You may apply for Spouse/Domestic Partner coverage in increments of $10,000 up to a maximum of $250,000, but not to exceed 100% of your combined Basic and Additional life coverage amount. There is a guarantee issue amount of up to $20,000 if you apply within 31 days of employment or benefits eligibility. A Medical History Statement or application for coverage is required for enrollments outside of this period and the application will be subject to The Standard Insurance Company's underwriting review process.

Dependent Life Insurance

You may apply for dependent life coverage for your dependent child(ren) in an amount of either $5,000 or $10,000. There is no medical underwriting approval requirement for this coverage; it is automatically approved. Dependent children age-out of coverage when they turn 26 years old.

When Coverage Terminates

If an employee leaves City employment current Life and AD&D insurance coverage is portable, meaning there will be an option to convert life insurance coverage to an individual whole life insurance policy. The application to port or convert life insurance must be completed within thirty-one (31) days of the employee's last day of employment with the City. After thirty-one (31) days, eligibility for this benefit ends. Coverage for dependent children terminates when the employee's coverage terminates, or when they no longer qualify as dependents.

SECTION 13: LONG TERM DISABILITY INSURANCE

City employees are not covered by State Disability Insurance (SDI) or Social Security. Consequently, the City offers two plan options for employee-paid Long-Term Disability (LTD) Insurance. Enrollment is voluntary. Long Term Disability is an insurance policy that pays employees up to 66 2/3% of their gross monthly salary, tax free if they become totally disabled on or off the job by an illness, injury, or pregnancy. The City program is offered through The Standard Insurance Company (The Standard).

All full-time and part-time benefited employees are eligible to participate in this program (temporary employees are not eligible for LTD).

For more detailed information, including the Certificate of Insurance and rates, visit the HR Benefits website.

Plan Options

There are two plan options for Long Term Disability insurance, LTD-30 and LTD-60. The following chart shows the differences between the two plan options.

	LTD-30 Plan	LTD-60 Plan
Benefit Percentage	66 2/3% of the first $15,000 of the employee's pre-disability earnings plus 40% of the next $12,500 of the employee's pre-disability earnings, reduced by deductible income.	66 2/3% of the first $15,000 of the employee's pre-disability earnings plus 40% of the next $12,500 of the employee's pre-disability earnings, reduced by deductible income.
Benefit Waiting Period	30 Days	60 Days
Pre-existing Condition Exclusion	None: All pre-existing conditions are covered	12-month exclusion for pre-existing conditions within the 90 days prior to the coverage effective date.
Mandatory Rehabilitation	Not Required	Required

When Coverage Begins

Coverage is guaranteed within 30 days of hire or first date of eligibility for benefits coverage. Thereafter, enrollment in this program requires completion of the enrollment form and the online medical questionnaire before coverage will be granted.

Cost

The current premium cost can be found on the Long-Term Disability webpage. Premiums are calculated based on a percentage of the employee's gross bi-weekly earnings. Premium payments are taken through regular payroll deductions on a bi-weekly basis. These deductions are taken after-tax to ensure that disability payments are not taxable when received.

Claim Applications

To receive Long Term Disability benefits, an employee must complete the claim telephonically (preferred method) or online. The employee is responsible to complete the Employee's Statement, Authorizations to

Obtain Information and the Attending Physician's Statement (completed by the employee's physician) and to submit these forms to The Standard within 90 days of the date he/she becomes totally disabled. The employee should contact his/her department timekeeper to complete the Timekeeper's Statement and ensure this form is submitted to Human Resources. Human Resources will submit the Timekeeper's Statement and the Employer's Statement to The Standard.

To file Telephonically please call Standard Insurance toll free (855) 579-1879 and be prepared to provide:

Employer: City of San José

Group Policy Number: 282971

Your name and social security number

Last date you were at work or anticipate leave begin date

Nature of claim/medical information

Your physician's contact information

How LTD Insurance Works

Once an employee's LTD claim is approved, benefits will be payable beginning on the day after the final day of the waiting period during which the employee experienced continuous total disability. Approved claimants will be eligible to receive a monthly benefit of up to 66 2/3% of their monthly wage or salary. For example, if an employee earned $3,000 per month immediately prior to his/her disability, this benefit ensures that he/she will receive $2,000 per month once his/her claim is approved.

Please note that while benefits are payable, any deductible income paid, such as sick leave, is subtracted from the maximum monthly disability benefit.

Waiver of Premium During Disability

Insurance premiums are waived during the time period when LTD benefits are being paid to the employee. Insurance premiums will resume when the disability benefit is no longer payable.

Deductible Sources of Income

Deductible benefits include sick leave, personal/executive leave and most disability and retirement income from other sources. These include employer programs (e.g., pensions, as well as paid sick leave), government programs (e.g., state disability, Social Security, or Workers' Compensation), and other group insurance. Other leave payments, including vacation and compensatory time, are **not** deducted from LTD insurance payments. Employees will receive a minimum LTD payment of $100 per month even if deductible benefits are more than 66 2/3% of the employee's salary.

Definition of Total Disability

During the Benefit Waiting Period (the first 30 or 60 days of continuous, total disability) and for the next twenty-four (24) months, total disability means the complete inability to engage in the employee's regular occupation with the City.

After that, total disability means the complete inability to engage in **any** employment or occupation for which the employee is reasonably qualified, or for which the employee becomes qualified through education, training, or experience.

LTD and Family Medical Leave

The first 12 weeks of the employee's absence due to disability will run concurrent with the Family and Medical Leave Act (FMLA) and/or California Family Rights Act (CFRA).

When Payable Benefits Terminate

After a determination is made that the employee is able to engage in any employment or occupation, the LTD benefit payments will cease.

Payments will also cease once the employee reaches the end of the maximum benefit period, which is limited by age. If an employee becomes disabled prior to age 62, benefits will continue during disability until the employee reaches age 65. If an employee becomes disabled at age 62 or older, the benefit duration is determined by the employee's age when disability ends, as indicated in the table below.

Age When Disability Begins	Maximum Benefit Period
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69 and above	1 year

LTD Claims Status

For questions about a claim that has been filed, contact The Standard at (855) 579-1879.

When Coverage Terminates

Coverage will terminate when an employee leaves City employment, ceases to be eligible, or fails to remit premium. There is no conversion provision associated with this policy.

SECTION 14: PERSONAL ACCIDENT INSURANCE

Personal Accident Insurance is available through the City's group policy with New York Life. This plan offers full 24-hour-a-day bodily injury protection against accidents anywhere in the world, on or off the job, on business, on vacation, and at home. Illnesses are not covered.

For more detailed information, including Certificate of Insurance and rates, visit the HR Benefits website.

To contact the Customer Service Center, please refer to the Provider Contact Sheet.

Eligibility

All full-time and part-time benefited employees are eligible for this insurance. Employees may insure themselves by using the Employee Only plan, or they may insure both themselves and family members under the Family Plan if:

- Eligible dependents include lawful spouses, domestic partners, and dependent children up to the age of 26, with no restrictions based on full-time student of marital status. In the event of a disability, coverage will conclude at age 26.

No person may be covered more than once under this plan. An employee cannot be covered both as an employee and covered as a spouse, domestic partner, or dependent child of another employee. Dependents are covered at specified percentages of employee's coverage.

Guaranteed Coverage

No underwriting information is required. You are **guaranteed coverage** if you are a benefited employee. Consequently, employees may apply for Personal Accident Insurance, increase the amount of coverage, or change plan selection at any time without having to obtain approval from the Life Insurance Company of North America.

When Coverage Begins

Insurance becomes effective on the latest of the following dates:

Employee

- the date the Employee becomes eligible;
- the date insurer receives the Employee's completed enrollment form and the required first premium, during his lifetime.

Eligible Dependents

- the date the Employee becomes eligible;
- the date the Employee's insurance becomes effective;
- the date the dependent meets the definition of Spouse or Dependent Child, as applicable;
- the date insurer receives a completed enrollment form for Spouse and Dependent Child coverage and the required first premium, during each dependent's lifetime.

New Born

Insurance becomes effective for a newborn Dependent Child automatically from the moment of the child's live birth. Insurance for that Dependent Child automatically ends 31 days later unless the Employee has a Spouse or other Dependent Children insured under this Policy or makes a request to cover the child and pays the required initial premium, during the child's lifetime.

Insurance Coverage

Payable benefits are determined by the specific nature of the accidental injury or death in accordance with group policy provisions. In general, the following events are all payable at 100% of the maximum benefit for which the participant is enrolled; however, some lesser combination of these tragic events may be payable at less than 100% of the benefit maximum.

- Loss of life
- Loss of any combination of hands, feet, or eyes
- Loss of hearing and speech
- Quadriplegia

For the employee, the maximum benefit coverage amount is the full amount of coverage elected. For eligible family members, the benefit coverage amount is a percentage of the employee's elected amount. Please refer to this policy's *Certificate of Insurance* for more detail regarding coverage.

Reductions in Coverage

The employee's coverage is reduced at age 75 and then at age 80.

Identity Theft Program

The employee and family members are automatically covered by the Identity Theft Program if enrolled in the Personal Accident Insurance plan. The Identity Theft Program defends employees against damages caused by identity theft. A personal case manager will assist with advice and select administrative tasks in order to rectify identity theft issues employees may have experienced.

When Coverage Terminates

Coverage will terminate when the employee leaves City employment, ceases to be eligible, or fails to remit premium. Coverage for the spouse terminates when he or she ceases to qualify as a legal spouse. Child dependent coverage will terminate when they cease to be eligible as a qualified dependent (see the *Eligibility* section above). Coverage for the spouse terminates when the employee's coverage terminates, or when he or she is no longer eligible, whichever occurs first. Coverage for dependent children terminates when the employee's coverage terminates, or when they no longer qualify as dependents.

Policy Conversion

If the employee leaves City employment before he/she reaches age 70, he/she may keep this insurance policy by converting to an individual policy. The employee pays the premium in effect for his/her age and occupation as of the last day of employment with the City.

SECTION 15: LONG TERM CARE INSURANCE

The City's LTC insurance plan, provided by Prudential Insurance Company of America (Prudential), covers expenses related to nursing home care, residential care, facility care, and community and home-based care, and is designed to help alleviate the financial burdens of participants who require these services.

Eligibility

No new enrollments are accepted starting July 1, 2013. For grandfathered enrollments, contact a Prudential customer service representative at 1-800-732-0416 for any benefit or coverage questions.

SECTION 16: DEFERRED COMPENSATION PLAN

The City of San José 457(b) Deferred Compensation Plan (Plan) was established under Section 457 of the IRS Code. It is a voluntary benefit that provides a convenient way for City employees to defer and invest a portion of their wages into a retirement account. Participants are eligible to contribute pre-tax and/or Roth (after tax) money directly from their paycheck up to limits set by the IRS. Employees can choose to contribute to both options which will provide distribution choices at retirement. Assets in the participants' account accumulate tax deferred until the participant initiates a roll-over, distribution, or required minimum distribution commences. Assets in the participants' account are made available for distribution upon a qualifying event taking place. Qualifying events are defined as retirement, separation from service, death, or an unforeseeable financial hardship.

The complete text of the Deferred Compensation Plan can be found in Chapter 3.48 of the San José Municipal Code.

Plan Options

Pre-Tax

Contributions and earnings on the investment in this plan are not subject too current federal or state income taxes. Taxes become payable when deferred income plus earnings are distributed, presumably during retirement when you are in a lower income tax bracket.

Roth Post-Tax

Contributions to this plan are considered "after-tax," which means taxes are withheld when you contribute. However, qualified distributions on your contributions plus any earnings are completely tax-free.

Earnings and contributions can be withdrawn tax-free if certain conditions are met (separation from service, age 59 ½ and invested at least 5 years) Presumably, employees may be in a higher tax bracket at the time of their retirement or separation from employment and pay less in taxes at that time.

Enrollment in the Plan

Employees may enroll at any time during their employment with the City. Enrollment options are as follows:

- Enroll in person with a service provider representative. Call the deferred compensation service provider at **(408) 881-0110** for enrollment information.
- Enroll by completing the EZ Enrollment Form located on the City's Intranet and Internet sites: http://www.sanjoseca.gov; https://www.sanjoseca.gov/your-government/departments-offices/human-resources/benefits/deferred-compensation-program
- Enroll online. Employees can access the Plan site and complete the enrollment process at https://sanjose.beready2retire.com/.

Maximum/Minimum Amount of Deferral

Under federal law, there is a **maximum** amount that may be deferred in a calendar year as set forth by the IRS. Contributions can be a % of gross compensation or a dollar limit not to exceed the contribution in effect for

the current year. The **minimum** amount that may be deferred is $25 per pay period. For maximum limits for the current calendar year, refer to the annual contribution limits on the City's Deferred Compensation internet at: http://www.sanjoseca.gov

How to Make Deferred Compensation Contribution Changes

Participants can make contribution changes online or by phone:

- **Online**: https://sanjose.beready2retire.com/
  Instructions for making online contribution changes can be accessed on the City's Deferred Compensation internet at: http://www.sanjoseca.gov
- **Phone**: (800) 584-6001

Paycheck deductions for deferred compensation will begin as soon as administratively possible, generally within 1-2 pay periods after the change is made.

Investment of Deferred Wages

The Deferred Compensation Advisory Committee (DCAC) overseas and manages the investment program. The DCAC and its independent advisor determines the investment vehicles offered in the plan. Participants have control over how and where their money is invested and can move the investment dollars between a selection of funds.

Participants' deferred income is placed in an account established for them with the plan administrator. All payroll deductions and interest earnings are credited to the account. All assets are held by the City in a trust for the exclusive benefit of the participants and beneficiaries of the Plan.

Participants have approximately 28 investment options to invest their deferred assets. Participants may transfer their money between investment options at any time.

Catch-Up Provisions

The IRS' has Special Catch-Up Provisions that allows participants to exceed the current designated annual maximum. These include:

- **Special 3-Year Catch-Up Provision:** allows participants to exceed the current designated annual maximum during the three (3) years prior to the year designated as the employee's normal retirement age in order to make up for years when they did not invest the maximum amount for which they were eligible if certain requirements are met.
- **Catch-Up Provision for Participants 50 Years or Older**: allows participants who are age 50 or older, or who will turn age 50 in the calendar year, to contribute an additional amount to the established annual maximum contribution limit.
- **Military Service Provision:** The Uniformed Service Employment and Re-Employment Act of 1994 (USERRA) allows members of the uniformed service to deposit missed contributions into their Deferred Compensation Account due to military service if certain requirements are met.

Contact the deferred compensation at HRBenefits@sanjoseca.gov for additional information regarding the Catch-up Provisions.

Loan Provision

The Plan provides flexibility through loan options for active employees. Participants can borrow money from their pre-tax Deferred Compensation account. There are 2 types of loan:

- General Purpose loans can be used for any reason and have a maximum repayment period of five (5) years.
- Residential loans must be used for the purchase or renovation of a primary residence and have a maximum repayment period of 20 years.

The Plan's loan program allows for a maximum of one (1) of each type of loan to be outstanding at any one (1) time. The minimum loan amount is $1,000 and the maximum loan amount is 50% of the participant's account value or $50,000, whichever is less.

Loan information can be obtained by contacting the deferred compensation service provider's customer service center at **(800) 584-6001.**

Beneficiary Designations

Beneficiary designations on deferred compensation accounts should be reviewed after any major life change.

If the participant is married and his/her spouse was not named as the beneficiary, the spouse may have community property rights to the account funds unless the spouse signs an acknowledgement that he or she is not a beneficiary.

Participants are encouraged to immediately provide their beneficiary information to the deferred compensation service provider as soon as possible. Participants can add or change their beneficiaries by accessing their deferred compensation account online at https://sanjose.beready2retire.com/ or by calling the deferred compensation service provider's customer service center at **(800) 584-6001**.

SECTION 17: TIME OFF - PAID AND UNPAID

Holidays

All eligible full-time employees receive fourteen (16) paid holidays per year. These holidays are:

- New Year's Day
- Martin Luther King Day
- Lunar New Year
- Presidents' Day
- Cesar Chavez Day
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Columbus Day
- Veterans' Day
- Thanksgiving Day
- The day after Thanksgiving
- Christmas Eve Day
- Christmas Day
- New Year's Eve Day

Note: Selected City offices and facilities are closed to the public during the holiday furlough (the days between Christmas and New Year's Eve). Essential services including, but not limited to, Police, Fire, Airport, and Environmental Services/Regional Wastewater Facility will continue to operate and certain scheduled recreational and cultural facilities and events will be held as scheduled. Department Directors will determine which services will remain open. City employees are asked to participate in the closure on a voluntary basis. If working during the closure is preferred, employees must notify their supervisor in advance to make arrangements for an assignment. Employees may be assigned to perform work outside of their usual assignment and possibly outside of their department.

During the closure, some work days do not fall on holidays. For these days, employees participating in the closure should record their time off as vacation, personal leave, compensatory time, or executive leave, if paid leave is desired (sick leave may not be taken).

Holiday pay is calculated by the number of hours for which the employee is regularly scheduled to work. Specified employees may receive pay in lieu of holiday time off. Holiday dates are published in a City Calendar that is distributed to all employees before the beginning of each year.

Vacation

Consult the applicable Memorandum of Agreement (MOA) or Benefit and Compensation Summary for information about the vacation time that employees earn each year that they work for the City and the vacation accrual maximum.

For employees working part-time, on a reduced workweek, or taking time off without pay, their vacation accrual is affected because vacation time is calculated by the number of hours for which they are paid. Employees do not accumulate extra vacation time for overtime hours worked.

Personal and Executive Leave

Some full-time and part-time non-management employees may also take personal and/or executive leave, subject to supervisor approval. Consult the applicable MOA or Benefit and Compensation Summary to learn if you are eligible for Personal or Executive Leave.

Executive leave is a benefit awarded to management employees as hours/days off, up to a maximum of forty (40) hours/ five (5) days during a payroll calendar year. The Management Performance Program (MPP) provides that employees may receive up to forty (40) hours of additional executive leave. Please refer to City Policy Manual (CPM) sections 4.2.4 and 3.3.2 for complete policy guidelines located on the City's Employee Relations public website.

When an employee is hired into a position eligible for personal or executive leave, the leave may be prorated during the first-year dependent upon the hire date.

Personal and executive leave is not an accrued benefit and unused leave does not carry over from year to year.

Sick Leave

All full-time employees may take their accrued sick leave with pay as medically required. Sick leave is for injuries or illness, and for routine medical and dental appointments. Employees may take sick leave to care for a sick dependent. Check the applicable MOA or Benefit and Compensation Summary and CPM section 4.2.6 located on the City's Employee Relations public website.

Employees must contact their supervisor before their scheduled work shift begins to advise them of the need to use sick leave. Substantiation (such as a doctor's certificate) may be required for any sick leave.

For employees working part time, on a reduced workweek, or taking time off without pay, their sick leave accumulation is reduced because sick leave time is calculated based on the number of paid hours. Employees do not accumulate extra sick leave for working overtime hours.

Some retiring employees may be eligible to receive pay for a percentage of their unused sick leave. Check the applicable MOA or Benefit and Compensation Summary for more information.

Sick Leave without Pay

Full-time employees may be eligible for unpaid leave of an absence due to a non-job-related illness, injury, or disability. This is considered *Sick Leave Without Pay*.

See the applicable MOA or Benefit and Compensation Summary for specific limits on the length of sick leave for your position. *Sick Leave Without Pay* is one example of *Leave of Absence Without Pay*, and all *Leave of Absence* procedures are applicable.

Bereavement Leave

Full-time or part-time benefited City employees may be eligible for paid leave in the event of the death of a relative.

The employee's supervisor may request verification for bereavement leave. Bereavement leave is not paid if an employee is not scheduled to work. For details, consult the applicable MOA or Benefit and Compensation Summary and CPM section 4.2.5 located on the City's Employee Relations public webpage.

Leave for Reproductive Loss

An employee may request to take up to five days of reproductive loss leave following a reproductive loss event. The days an employee takes for reproductive loss leave may be nonconsecutive. Reproductive loss leave shall be completed within three months of the event entitling the employee to that leave.

Reproductive loss leave may be unpaid, except that an employee may use bereavement in the event of a miscarriage or stillbirth. An employee may use accrued and available vacation, personal, executive, sick or compensatory time off otherwise available to the employee.

If an employee experiences more than one reproductive loss event within a twelve-month period, the City shall not be obligated to grant a total amount of reproductive loss leave time in excess of twenty days within a twelve-month period.

If, prior to or immediately following a reproductive loss event, an employee is on or chooses to go on leave from work pursuant to PDL, FMLA/CFRA, or any other leave entitled under state or federal law, the employee shall complete their reproductive loss leave within three months of the end date of the other leave. For purposes of reproductive loss leave, the following definitions apply:

1. "Employee" means a person employed by the City for at least 30 days prior to the commencement of the leave.

2. "Reproductive loss event" means the day or, for a multiple-day event, the final day of a failed adoption, failed surgery, miscarriage, stillbirth, or an unsuccessful assisted reproduction.

3. "Failed adoption" means the dissolution or breach of an adoption agreement with the birth mother or legal guardian, or an adoption that is not finalized because it is contested by another party. This event applies to a person who would have been a parent of the adoptee if the adoption has been completed.

4. "Failed surrogacy" means the dissolution or birth of a surrogacy agreement, or a failed embryo transfer to the surrogate. This event applies to a person who would have been a parent of a child born as a result of the surrogacy.

5. "Miscarriage" means a miscarriage by a person, by the person's current spouse or domestic partner, or by another individual if the person would have been a parent of a child born as a result of the pregnancy.

6. "Stillbirth" means a stillbirth resulting from a person's pregnancy, the pregnancy of a person's current spouse or domestic partner, or another individual, if the person would have been a parent of a child born as a result of the pregnancy that ended in stillbirth.

7. "Unsuccessful assisted reproduction" means an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure. This event applies to a person, the person's current spouse or domestic partner, or another individual, if the person would have been a parent of a child born as a result of the pregnancy.

8. “Assisted reproduction” means a method of achieving a pregnancy through an artificial insemination or an embryo transfer and includes gamete and embryo donation. Assisted reproduction does not include any pregnancy achieved through sexual intercourse.

For absences related to reproductive loss, please submit a Reproductive Loss Leave Form.

Jury Duty Leave

Benefited employees serving as jurors will receive their regular pay; however, if employees receive jury fees, they must remit them to the City. Employees may keep their mileage payment.

Witness Leave

Each full-time employee of the City who is required, under subpoena, to take time off duty with the City, to appear as a witness, because of their employment with the City, in any case or proceeding in any Court of this State or of the United States of America, shall receive their regular salary during the term of their service as a witness under subpoena, less any and all witness fees which the employee may receive therefore. Compensation will not be paid if the employee is a party to a state or federal action.

Please see the applicable MOA or Benefit and Compensation Summary for specific details.

Military Leave

The City of San José has a separate policy for Officers and employees of the City of San José who are entitled to benefits for military service in accordance with applicable laws of the State of California and the Federal Government. Please refer to City Administrative Policy manual 4.2.2 Military Leaves policies and procedures related to the use of military leave by City employees.

Please refer to City Policy Manual Section 4.2.2 located on the City’s Employee Relations public webpage.

Family and Medical Leave Act, California Family Rights Act, and Pregnancy Disability Leave Act

INTRODUCTION

The Family and Medical Leave Act (FMLA) of 1993, provides unpaid leave to eligible employees with qualifying circumstances and ensures that employees will be reinstated to the same or equivalent position with no loss of benefits once the leave is concluded.

In California, employees are also covered by the California Family Rights Act (CFRA) of 1993 and the Pregnancy Disability Leave Act (PDL), each of which provide family or medical leave that can run concurrently or consecutively with the FMLA, depending on the circumstances.

These pieces of legislation were implemented to allow employees to secure leaves from work under certain specified conditions while also providing job security and health care benefits. These laws also have an impact

on other statutes such as Workers' Compensation and internal leave policies.

LEAVE ENTITLEMENT

In accordance with the requirements of the FMLA and the CFRA, as amended, the City of San José will provide an eligible employee with up to twelve (12) weeks of protected leave during each year if the employee is eligible for FMLA/CFRA leave. Any employee (including temporary, part time, or seasonal) who has been maintained on the City payroll for at least twelve (12) months and who has worked at least 1,250 hours (actual working hours including overtime) during the previous twelve (12) months for the City of San José is eligible for time off work under this policy for any of the qualifying reasons outlined below. (NOTE: The 12 months of employment with the City need not be consecutive; however, employment periods prior to a break in service of seven years or more shall not be counted in determining whether the employee has been employed by the employer for at least 12 months, except for a break in service cause by a military service obligation).

Under the provisions of the FMLA/CFRA, "leave" from work may be taken for any of the following reasons:
a. For the birth of the employee's son or daughter and to care for the newborn child;
b. To care for a child placed with the employee for adoption or foster care;
c. To care for the employee's child, spouse, registered domestic partner (CFRA only), parent, parent-in-law (CFRA only), grandparent (CFRA only), grandchild (CFRA only), sibling (CFRA only) or designated person (CFRA only) who has a serious health condition;
d. The employee's own serious health condition that makes the employee unable to perform the essential functions of the employee's position; and
e. Because of any qualifying exigency arising out of the fact that the spouse, registered domestic partner (CFRA only) child, or parent of the employee is on covered active duty (or has been notified of an impending call or order to covered active duty) in the Armed Forces.

It is also important to keep in mind FMLA/CFRA leave is unpaid leave. FMLA/CFRA leave is an employee's right to be away from the job while still enjoying certain statutory protections provided by law. Depending upon the reason for the leave, the employee may be required to use and exhaust all accrued sick leave and/or accrued vacation while on unpaid FMLA and/or CFRA leave. Additional information on the use of paid leave during FMLA and/or CFRA can be found in the City Policy Manual, Section 4.2.1 Leaves of Absence located on the City's Employee Relations public webpage.

Employee Rights and Benefits Under FMLA/CFRA

Any City employee who is granted time off work for an FMLA/CFRA qualifying reason is eligible to receive the following benefits:

1. Retention of employment status (i.e., position, seniority, benefits) with the City of San José during the period of time off;

2. Reinstatement to the same or equivalent position after the twelve (12) week period of time off is concluded; in some instances, this may be more than twelve weeks.

3. Group health plan benefits continue the same as coverage would have been provided if the employee had been continuously employed during the 12 week leave period. If the employee is disabled by pregnancy, the employee will continue to be covered for up to 4 months each leave year. In the event an employee is disabled by pregnancy and also uses CFRA for bonding, the City of San José will maintain the employee's health benefits while the employee is disabled by pregnancy (up to four months or 17 weeks) and during the employee's CFRA leave (up to 12 weeks).

4. Entitlement to continuation of group health benefit plan under the Consolidated Omnibus Reconciliation Act (COBRA) of 1986;

5. Protection against unlawful discharge or discrimination associated with the leave.

How to Apply for FMLA and CFRA Leave

FMLA/CFRA is unique in that it may be initiated by either the City or at the request of the employee. Whenever an employee is absent or expected to be absent from work for a period in excess of two weeks, the Department/Division shall request that the employee provide information regarding the absence in order to determine if an FMLA/CFRA leave designation is appropriate**. Exception:** Any leave charged to an absence which relates to a job-related injury (except those covered under LC 4850) shall be immediately designated as FMLA/CFRA for all time lost due to the injury.

Beginning April 2023, employees and departments will submit Leave of Absence Request via eWay. *The PDF Leave of Absence Application form should no longer be used or used only in limited circumstances.*

The link to the Leave of Absence Request can be found in the "Time and Attendance" section under "Employee Quick Links" or **Main Menu->Self Service->Leave of Absence Request**. Simply, click the "Leave of Absence Request" link to get started.

If possible, please have any medical certification and/or leave schedule saved to your computer and available to upload during the submission process. If not, please upload as soon as possible after submitting your request. See Document Upload Guide for instructions.

Please refer to the guides listed on the HR Leaves of Absence webpage to assist you in navigating the new process

Employees must provide no less than a thirty (30) day notice before any FMLA/CFRA leave is to begin. An exception can be made when the thirty (30) day advanced notice cannot be reasonably anticipated nor predicted by the employee. FMLA and CFRA leave will not be approved after the FMLA and CFRA entitlement period ends (FMLA and CFRA entitlement period is limited to 12 workweeks per year).

How Much FMLA and CFRA Leave Can Be Taken?

An FMLA/CFRA leave may be taken in one twelve (12) workweek period with one exception. For leave to care for a Covered Service member, the maximum combined leave entitlement is 26 weeks, with leaves for all other reasons constituting no more than 12 of those 26 weeks. Also, in addition to leave available under the FMLA and CFRA, female employees may be eligible for leaves of absence during periods of disability associated with pregnancy or childbirth. Please see the Pregnancy Disability Leave of Absence (PDL) section for further information on this type of leave.

The FMLA/CFRA time off work does not have to be in one twelve (12) week increment. An employee may take time off work intermittently (a few weeks/days/hours at a time) under certain conditions.

Pregnancy Leave: FMLA, CFRA and PDL

If an employee is disabled due to pregnancy, childbirth, or related medical conditions, the employee may be eligible for up to four (4) months of leave, in conjunction with the FMLA leave, under the California Pregnancy Disability Leave Act (PDL).

The State CFRA statute does not consider pregnancy to be a disability since there is another California law, Pregnancy Disability Leave (PDL), which addresses this matter. If eligible, FMLA and PDL run concurrently, CFRA does not run concurrently with PDL. The employee is entitled to take CFRA leave if they meet the CFRA eligibility requirements after PDL entitlement ends. This benefit is only permitted during the period the employee is deemed disabled as documented by the treating physician. Generally, following the period of disability, the employee would be eligible to take an additional 12 weeks off work under the CFRA statute. CFRA basically provides an opportunity to "bond" with the newborn.

Under these conditions, an employee could potentially remain off work for a maximum of up to 4 months (Pregnancy Disability Leave) and an additional 12 weeks (CFRA bonding leave). As a reminder, there cannot be any overlap between a PDL and CFRA leave for pregnancy related disabilities. PDL is based on the existence of a medical disability associated with the pregnancy while CFRA is a bonding leave with the newborn.

Eligibility for PDL leave commences with the date of employment. Unlike the FMLA/CFRA, there is no service eligibility requirement pertaining to the one-year period of service or minimum number of hours worked.

See Section 19: Benefits Continuation During Leave of Absence for benefit premiums.

Medical Certification Is Required for FMLA, CFRA, and PDL Leave

Medical certification is required to be completed by the employee's health care provider in order to verify that the employee is taking leave for a qualified FMLA, CFRA, and/or PDL reason. The FMLA, CFRA, and/or PDL medical certification must contain the following:

- **For FMLA and/or CFRA leave for the employee's own illness or injury:**

Medical certification of the employee's "serious health condition" as described in the federal Family and Medical Leave Act and California Family Rights Act; the approximate date the medical condition began; the probable duration of the condition; the probable duration of the inability to work due to the condition; certification that the employee is unable to perform one or more of the essential functions of their job.

- **For FMLA and/or CFRA leave to care for an eligible family member:**

Medical certification of the same information described above regarding the employee's family member's illness or injury; the doctor's statement that the employee must be absent from work to care for this family member; and estimate of the period during which this care is required for the family member (including the anticipated work schedule if the leave will be taken on an intermittent basis to care for a family member).

- **For PDL leave for employees who are specifically disabled due to pregnancy-related conditions**

Medical certification is required from your health care provider for Pregnancy Disability Leave. For this purpose, the medical certification of the same information described above regarding the employee's pregnancy disability.

Medical certification for FMLA and/or CFRA leave must be provided directly to Employee Benefits, City of San José – Human Resources, 200 E. Santa Clara St., 4th Floor Tower, San José, CA 95113. Since this information is confidential, it **should not** be attached to the *Leave Application*. A medical certification form is available from the department Timekeeper, Department of Human Resources, or online on the Leave of Absence webpage for the employee and the employee's doctor to use in providing the medical certification required for FMLA and CFRA leave.

A "Doctor's Note" is generally not sufficient to provide FMLA and CFRA or PDL medical certification. FMLA , CFRA, and/or PDL medical certification is separate from and in addition to any statement or form which may be required for any insurance purpose including a claim for Long Term Disability Insurance provided by The Standard Insurance Company. Leave under the FMLA , CFRA, and/or PDL may not be approved until the FMLA , CFRA, and/or PDL medical certification has been received by Human Resources.

An employee is required to submit a completed medical certification from a health care provider within no less than fifteen (15) days whenever FMLA/CFRA/PDL time off work is needed due to the serious health condition of the employee, the employee's immediate family member, or disabled by pregnancy. Failure to provide the required medical certification within fifteen (15) days of the City's request, or if the employee fails to provide a complete and sufficient certification despite the opportunity to cure any deficiencies, may result in the leave not being designated as FMLA/CFRA/PDL which may also result in the denial of the leave.

Paid Parental Leave

Full-time City employees (35+ scheduled hours), who have completed at least 2,080 hours of service from their most recent hire date may be eligible for 40 hours (1 week) or 320 hours (8 weeks) of paid time and use up to 120 hours or personal sick accruals for the employee's or the employee's spouse/domestic partner's new child (birth, adoption, or foster care placement). The amount of City-paid leave is determined by an employee's union. Please refer to the table below showing Paid Parental Leave Benefit by Bargaining Unit for specific eligibility.

1 week/40 hours	8 weeks/320 hours	
IBEW	ABMEI	MEF
POA	AEA	SJPDA
OE3	ALP	POPRA
	AMSP	Unit 99/81/82
	CAMP	
All groups above: Use of up to 120 hours of employee's sick leave		

City-Paid Parental Leave and the use of available sick leave balances for City-Paid parental Leave reasons must be used and completed no later than 12 months from the birth or placement of a child and employees are eligible to use each component once per event/child per payroll calendar year. Paid Parental Leave shall be provided once per event (birth/placement) per payroll calendar year.

To apply for Paid Parental Leave, employees must submit a leave of absence request in eWay 30 days prior to the commencement of the leave where possible. Paid Parental Leave hours and 120 of personal sick hours do not need to be used consecutively; however, the time should be taken in a minimum duration of 2 weeks except for on two

occasion the time off can be less than two weeks for all protected leaves.

Eligible employees must also submit documentation that shows the date of birth/placement and parent(s) name. For birth, this can be a Birth certificate, Certificate of Live Birth, or a medical provider note showing the names of parent(s) and date of birth. For adoptions/foster placement, this can be an official court-recorded document indicating the date of placement and the names of the parent(s)/guardian(s).

If documentation is not available at the time of the leave request, employee's leave request will still be reviewed and processed by Human Resources. Once the document(s) become available, the employee is required to upload these directly into eWay for eligibility verification. Please see the Document Upload Guide for further instructions.

For more information regarding the City's Paid Parental Leave program, please visit the Human Resources Leave of Absence web page, and review the Paid Parental Leave Overview + Frequently asked Questions.

Recertification of Health Condition

The law provides that once an employee has provided certification of a medical condition, a recertification cannot be requested for a period of 30 days. Exceptions to this 30-day rule exist when there is a showing that one of following events has occurred:

1. The employee requests an extension of the leave; or

2. The circumstances described by the original certification have changed significantly; or

3. The employer has information that casts doubt on the continuing validity of the certification. Documentation is important to show a pattern of leave abuse.

If the City has received a complete and sufficient certification but has a reason to doubt that it is valid, the City may require the employee to obtain a second medical certification. Please see City Administrative Manual Leave of Absence Policy 4.2.1 for further details.

Service Member Family and Medical Leave

An eligible employee may take up to twelve (12) workweeks off during a twelve (12) month period because of any qualifying exigency arising out of the spouse, son, daughter, or parent of the eligible employee being on covered active duty (or has been notified of an impending call or order to covered active duty) in the Armed Forces; or

An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member shall be entitled to a total of twenty-six (26) workweeks of leave during a twelve (12) month period to care for the covered service member with a serious injury or illness.

For additional information please refer to City Policy Manual Section 4.2.1.

Vacation, Sick Leave, And Service Credit

When an employee takes a leave of absence without pay, the following items, determined by the number of hours the employee works, are affected as follows:

- Vacation, sick leave, retirement service hours, and seniority hour balances cease to accumulate.
- The timing of step increases is delayed.
- Completion of probation is delayed.

Leave of Absence Extensions

Any extension to a leave of absence must be requested in writing prior to the end of the employee's leave.

End of Leave of Absence

Failure to return to work immediately following the end of an approved leave of absence will be considered a voluntary resignation. An employee who takes time off under FMLA/CFRA due to his/her own serious health condition may be required, prior to his/her return from the FMLA/CFRA leave, to provide a medical certification verifying he/she is able to return from medical leave and perform his/her job duties.

Returning from a Leave of Absence

When employees return from a leave of absence, their supervisor must complete a *Return from Leave* form and turn it in to their leave Analyst in Human Resources.

If coverage has been dropped from any City benefit plans because the employee did not pay his/her own premiums during their leave or the employee elected to have all benefits lapsed, the employee will be required to re-enroll upon his/her return from leave. For some benefits, the employee may be subject to Evidence of Insurability (EOI). Coverage will begin again once the appropriate premiums are paid, but no sooner than the first of the month following the return from leave. Please contact Human Resources by phone at 408-535-1285 or by e-mail at HRBenefits@sanjoseca.gov for more information.

What Happens When An Employee's FMLA/CFRA Expires?

Upon the expiration of the protected leave, all the outlined benefits that FMLA/CFRA provide are concluded. The employee may continue leave beyond the statutory protected period with the approval of Other Leaves Without Pay, consistent with the Leaves of Absence Policy.

Cancer Screening Release Time Program

The purpose of this program is to allow City of San José Civil Service employees (classified and unclassified) time away from work to receive breast and prostate cancer screening. Because early detection and diagnosis of such

cancers can save lives, the goal of the City of San José is to encourage its employees to schedule and receive regular breast and prostate screenings through their health care provider to increase the benefits of prompt treatment.

Please refer to City Policy Manual (CPM) Section 4.2.13 for more information. The CPM and the Cancer Screening Release Time form can be found on the City's Intranet site at: http://www.sanjoseca.gov/index.aspx?NID=3843.

SECTION 18: BENEFITS CONTINUATION DURING LEAVE OF ABSENCE

Paid Leaves of Absence

Benefit premiums are paid through regular paycheck deductions taken each pay period. If an employee is in a protected and unprotected paid status and continues to receive a City paycheck, both the employee's and the City's premium contributions will continue to be made to the City's respective benefit providers. Consequently, employees on paid leave of absence do not need to do anything to maintain their benefits eligibility.

Unpaid Leaves of Absence

When an employee enters into an unpaid protected or unprotected status while on leave, City paychecks will cease and the employee and City portions (if applicable) of the premium contributions will stop. This lack of premium contribution will interrupt benefits eligibility within both the City's and the benefit providers' systems.

Benefits Continuation During Family and Medical Leave (FMLA), California Family Rights Leave(CFRA) and Pregnancy Disability Leave (PDL)

Family and Medical Leave (FMLA), California Family Rights Leave (CFRA), and Pregnancy Disability Leave (PDL) are considered protected leaves. While on an approved protected leave, employees will be entitled to the City's regular contribution to Medical, Dental, Vision (if applicable) and EAP benefit premiums for the protected period of leave time allowed by legislation (See the *Employee Benefits Handbook, Section 18 Time Off Paid and Unpaid*, and the *City Policy Manual, Section 4.2.1 Leaves of Absence* for additional information on FMLA/CFRA/PDL).

For employees in a paid status and on protected leave, the employee's and the City's premiums will be collected and remitted as usual through regular paycheck deductions. If and when an employee enters into unpaid status on protected leave, employees will be responsible for remitting their portion of the regular premium; the City will continue its portion through the remainder of the protected leave time. If the leave is not qualified for FMLA, CFRA or PDL, the employee must make payments of both the employee and City portion of the premium to continue coverage.

The City may recover from the employee any premiums paid on behalf of the employee for group health care coverage if the employee fails to make payments for health premiums during FMLA, CFRA and/or PDL leave, or if the employee fails to return to work. If the employee is no longer eligible for FMLA/CFRA/PDL, the coverage under the health plans will be terminated and the employee will be offered COBRA coverage.

Benefits Continuation During a Protected Unpaid Leave of Absence

During a protected unpaid FMLA/CFRA/PDL leave, the employee's portion of the insurance premiums must be received by the first of each month either by mail or in person. If the payment is more than 30 days late, the employee's insurance benefits may be dropped by the vendor for failure to make a premium contribution. The City will provide a fifteen (15) day notification prior to the employee's loss of coverage. The employee may be invoiced for any insurance premiums that cannot be cancelled retroactively.

Beginning an Unpaid Leave of Absence

If an employee anticipates going into an unpaid status while on protected leave, it is the employee's responsibility to contact Human Resources (City Hall Tower, 4th Floor, 408-535-1285, HRBenefits@sanjoseca.gov) for information regarding premium and benefits continuation. Human Resources will provide information to assist employees with continuing benefits to avoid a break in coverage.

Employee Entitlement to Continuation of Health Benefits under COBRA

The last day of FMLA, CFRA and/or PDL time off work is the end of the protected period OR the date the employee informs his/her Department that he/she (i.e., the employee) will not be returning to work, whichever occurs first. Once FMLA, CFRA and/or PDL have been exhausted, if the employee still cannot come back to work whether the employee is on ADA additional leave or not, coverage under the health plans will be terminated and employees on leave will be offered COBRA coverage. An employee who does not return to employment with the City at the end of any protected time off work may have the right to select COBRA coverage.

Americans with Disabilities Act (ADA) and FMLA/CFRA

Any City employee with a serious health condition, who is eligible for time off work under the FMLA/CFRA and who also meets the criteria of being a qualified individual with a disability under the Americans with Disability Act (ADA) is entitled to his/her rights under all statutes including the ADA, FEHA, FMLA, and CFRA. For example, an FMLA/CFRA eligible employee who is working part time due to reasonable accommodation under the ADA, may take FMLA/CFRA time off work for any of the qualifying reasons under FMLA/CFRA.

Workers' Compensation and FMLA/CFRA

When an employee is injured on the job and the injury also results in a serious health condition that makes an employee unable to perform any one of the essential functions of the employee's position within the meaning of FMLA/CFRA, the employee qualifies for both Workers' Compensation benefits and FMLA/CFRA. This excludes safety employees covered under LC 4850. Both Workers' Compensation and FMLA/CFRA run concurrently.

All charged time off due to an employee's absence for a Workers' Compensation injury is charged against the 12-week entitlement to FMLA/CFRA leave for all FMLA/CFRA eligible employees except sworn safety employees covered under LC 4850.

FMLA/CFRA and Retirement Plans

Any period of FMLA/CFRA/PDL leave will be treated as continuous service for purposes of vesting and eligibility to participate in the City's retirement plan.

A City employee is entitled to the right of reinstatement to the same or equivalent position and equivalent benefits after the conclusion of an unpaid FMLA/CFRA/PDL leave, including the retirement benefit plan.

Employee Protection Against Unlawful Employment Practices

Any City employee who has used FMLA/CFRA/PDL leave shall be protected against unlawful employment practices. It is unlawful to discharge, discriminate, interfere with, restrain, or deny any employee the ability to exercise or attempt to exercise any leave or right granted under the provision of the FMLA or CFRA.

Additional Information

Each leave of absence is different, and contacting Human Resources prior to the beginning of a LOA is recommended. More information is available from Human Resources (City Hall Tower, 4th Floor, 408-535-1285, HRbenefits@sanjoseca.gov).

SECTION 19: TIME DONATION PROGRAMS

Catastrophic Illness/Injury Time Donation Program (CITD)

This program is designed to assist an employee who has exhausted paid leave time due to the employee's critical medical condition (illness/injury is extremely serious, totally incapacitating, and life-threatening) or, depending on the bargaining unit, critical medical condition of an eligible family member. Voluntary donations are intended to assist the seriously ill or injured employee who would otherwise have no regular income. Employees who are covered by the City's group insurance plan for salary continuation such as voluntary Long-Term Disability (LTD), are encouraged to file a claim with the LTD carrier in lieu of applying for the CITD program. This program allows other employees to donate earned vacation and/or compensatory time in accordance with the following terms so an employee may continue in a paid status with the City for a longer period.

The CITD program requires that the applicant must be absent for at least 30 consecutive days, or cumulative days within the last 6-months due to the non- work-related illness/injury and have exhausted all paid leave by the time the donation can be processed. The donation hours that can be received is limited to a maximum of 1,040 hours with the option to increase to a maximum of 2,080 hours, if eligible.

Please refer to the applicable Memorandum of Agreement (MOA) for union-specific requirements, if applicable. Also, please consult City Policy Manual (CPM), Section 4.2.10, *Time Donation Programs,* for more details regarding policy and administrative procedures. The City Policy Manual can be found on the City's public website.

Personal Illness/Injury Time Donation Program (PITD)

This program is designed to assist an eligible City employee who has exhausted paid leave time due to an employee's non-critical medical condition. This provision allows other employees to donate earned vacation and/or compensatory time in accordance with the following terms so an employee may continue in a paid status with the City for a longer period.

The PITD program requires that the applicant must be absent for at least 30 consecutive days due to a non-work related illness/injury, and have exhausted all paid leave by the time the donation can be processed. The maximum donation that can be received is limited to 176 hours.

Please refer to the applicable Memorandum of Agreement (MOA) for additional information. Also, please consult City Policy Manual (CPM), Section 4.2.10, *Time Donation Programs,* for more details regarding policy and administrative procedures. The City Policy Manual can be found on the City's public website.

SECTION 20: WORKERS' COMPENSATION

California Workers' Compensation law, passed by the state Legislature more than ninety years ago, guarantees prompt, automatic benefits to workers injured on the job.

It's the Employee's Responsibility to report an on-the-job injury or illness

An employee who is injured on the job must report it to his/her supervisor (or the next level in chain of command) immediately. If time could be lost from work, a physician should be seen within 24 hours. California law provides benefits to employees who are injured on the job or contract a job-related illness. Benefits vary with each situation. Employees should keep their supervisor aware of their current status.

For more detailed information, visit Workers' Compensation at City Hall, 200 E. Santa Clara St., 4th Floor Tower, or call (408) 535-1285.

Eligibility

All City employees are covered under Workers' Compensation law. Unpaid volunteers may not be covered.

Coverage

Any injury or illness caused by your job is covered, including everything from first-aid type injuries to serious accidents. Job-related illnesses may qualify for workers' compensation coverage as well.

Benefits and Payments

For a complete description of Workers' Compensation benefits and payment information, please consult the "*Facts about Workers' Compensation*" brochure included with new employee enrollment materials.

Workers' Compensation and Family and Medical Leave Act (FMLA)

Time spent on a leave of absence for workers' compensation counts towards an employee's annual 12-week entitlement to FMLA. More information on FMLA can be found in the Employee Benefits Handbook, Section 18 Time Off: Paid and Unpaid of and in the City Policy Manual, Section 4.2.1 titled Leaves of Absence.

SECTION 21: EMPLOYEE DEVELOPMENT

Workforce Learning and Development

Workforce learning and development (WL&D) is a systematic process to enhance an employee's skills, knowledge, and competency, resulting in better performance in a work setting. HR Workforce Learning and Development provides employees with the skills and knowledge they need to grow in their roles while helping grow our organization. For more information on WL&D including tools and resources visit the employee WL&D SharePoint site.

Education Benefits for Non-Management Employees

The purpose of the City's Education Reimbursement Program is to encourage full-time and part-time benefited employees to improve their job skills and performance by providing financial assistance for successful completion of job-related academic, professional, and technical course work. To qualify for reimbursement under the program, the proposed course work must improve the employee's skills and knowledge as required by the employee's present position; benefit the employee's professional development as a City employee; or enhance the employee's career development with the City of San José.

Please refer to the applicable Memorandum of Agreement (MOA) for union-specific requirements. Consult the City Policy Manual Section 4.3.1, *Education Reimbursement,* for more details regarding policy and administrative procedures. The City Policy Manual can be found on the City of San José public website.

Education Benefits for Management Employees

The purpose of the Professional Development Program for Executive Management and Professional Employees is to encourage eligible employees to maintain professional skills and knowledge and to further professional growth and development by providing funds for eligible educational and professional related expenses.

Please refer to the applicable Memorandum of Agreement (MOA) for union-specific requirements. Consult the City Policy Manual Section 4.3.2, *Professional Development Program,* for more details regarding policy and administrative procedures. The City Policy Manual can be found on the City's public website.

SECTION 22: ALTERNATIVE WORK SCHEDULES

Alternative Work Schedule Program

The Alternative Work Schedule program allows certain employees to request a biweekly work schedule other than the normal schedule of five 8-hour days each week. Applications are available from the Department Timekeeper or the Office of Employee Relations.

An Alternative Work Schedule is subject to approval by the Department Head and Office of Employee Relations, and is intended to be the employee's permanent schedule, although it may be terminated or revised to meet the employee's changing needs or the needs of his/her work unit. Consult the applicable MOA to see if the Alternative Work Schedule program is available to you and the City Policy Manual Section 4.2.11. The City Policy Manual can be found on the City's public website.

Reduced Work Week Program

All employees except police and fire (sworn) personnel may request a reduced work week for personal or medical reasons. The employee's department has complete discretion regarding approval unless a documented medical condition is the reason for the reduced work week request.

The City's contribution towards premiums for medical, dental and life insurance are prorated from the amount contributed for full-time employees, based on the number of work hours scheduled per week under each individual reduced work week agreement. Applications and additional information are available from Human Resources (City Hall Tower, 4th Floor, 408-535-1285, HRbenefits@sanjoseca.gov). For more information, please refer to the City Policy Manual Section 4.2.12. The City Policy Manual can be found on the City's public website.

SECTION 23: EMPLOYEE WELLNESS PROGRAM

The City of San José strives to provide employees with a positive, educational, and supportive environment, fostering a culture of health and wellness. That's why we offer a comprehensive employee wellness program designed to help our employees lead happier, healthier lives both at work and at home.

Our employee wellness program includes a range of activities and resources, designed to promote physical activity, mental and emotional well-being, and financial wellness. From fitness and nutrition classes to stress management workshops or financial planning for retirement we have something for everyone.

Physical Health:

- Virtual fitness classes: We offer a variety of fitness classes, including yoga, Pilates, and strength training taught by certified instructors
- Physical Activity Challenges: Wellness challenges are promoted throughout the year that focus on physical activity such as our annual Walktober Challenge.
- Ergonomic Assessments: We provide ergonomic assessments to help employees adjust their workstations for optimal comfort and productivity.

Mental and Emotional Health:

- Stress management workshops: Our stress management workshops are designed to help employees reduce stress, increase productivity, and improve overall well-being.
- Mindfulness and meditation sessions: We offer mindfulness workshops and an annual meditation series to help employees increase focus and concentration, reduce stress, and improve their overall well-being.
- Employee assistance program: We have an employee assistance program (EAP) to help employees cope with personal and work-related stressors.

Financial Wellness

- Retirement Planning: We provide resources and guidance on retirement planning, including our 457 Deferred Compensation plan, investment options, and pension benefits.
- Investment workshops: We offer investment workshops to help employees understand the basics of investing and make informed investment decisions.
- Portfolio analysis: Employees have an opportunity to meet with our onsite Voya Financial representatives to help understand their current investments and make necessary adjustments to reach their financial goals.

The City of San José is committed to promoting health and wellness among our employees. We encourage all employees to take advantage of the resources and activities we have to offer.

Employee Wellness Rewards*

The City of San José strives to help employees maintain or attain a healthy lifestyle and to help them be more informed medical consumers. The Wellness Rewards Program gives employees the opportunity to earn up to $50.00 for fulfilling certain wellness requirements.

BASIC PROGRAM (reward: $35.00)

- Choose a Primary Care Physician (PCP) and Dentist.
- Complete the annual preventative medical, dental, and vision check-ups and biometrics screening.
- Monitor your cholesterol levels, weight, blood pressure, and glucose.

ENHANCED PROGRAM (additional $15.00)

- Complete all steps of the Basic Program.
- Use an alternative mode of transportation to get to work, or is approved to maintain an alternative work schedule per their department.

You may elect to participate in the Wellness Rewards Program as a new employee, newly eligible for benefits or during open enrollment. Employees can enroll in the program at any time, prior to the enrollment deadline of September 30 of a given year. Employees need to re-enroll in the program each year during the Open Enrollment period.

For more information, visit the Employee Wellness SharePoint site.

*The Employee Wellness Rewards is subject to availability of annual funding.

City-wide Wellness Challenges and Monthly Wellness Event Calendar

City employees can visit the Employee Wellness SharePoint site to learn about City-wide wellness challenges and free monthly wellness webinars. City-wide wellness challenges are open to all City employees and City employee household family members to participate. Webinar recordings of the monthly classes are also available on the Employee Wellness SharePoint site for review.

Kaiser Permanente Wellness Support

Kaiser Permanente members can take advantage of the extra perks below—from personal health coaching to discounts on alternative medical therapies.

Healthy Lifestyle Programs

With the online wellness programs, members get advice, encouragement, and tools to help create positive changes in their life.

Kaiser's complimentary programs can help members lose weight, eat healthier, quit smoking, reduce stress, and manage ongoing conditions like diabetes or depression.

The Total Health Assessment is simple online survey that gives a complete look at one's health. Results of the assessment can be linked to the member's electronic health record, to share and discuss with the primary care provider.

For more information, visit Kp.org/healthylifestyles.
https://healthy.kaiserpermanente.org/northern- california/health-wellness/healthy-lifestyle-programs

Wellness Coaching

Kaiser offers Wellness Coaching by phone at no cost to members. For more information, visit kp.org/wellnesscoach. https://healthy.kaiserpermanente.org/northern-california/health-wellness/wellness-coaching

Health Classes

With all kinds of health classes and support groups offered right at Kaiser facilities, there's something for everyone. Classes vary at each location, and some may require a small fee.

Visit Kp.org/classes to see all available classes.

Member Discounts

Members get reduced rates on a variety of health-related products and services though ChooseHealthy™ . These include:

- Acupuncture – 25% off a contracted acupuncturist's regular rates
- Massage therapy - 25% off a contracted massage therapist's regular rates
- Chiropractic Care - 25% off a contracted chiropractor's regular rates
- Gym Memberships – 10% off participating fitness facilities

Members can also get reduced rates on vitamins and supplements.

See the Kaiser ChooseHealthy program flyer for more information.

Anthem Health and Wellness

Anthem provides a unique blend of health and wellness programs to help keep all employees at their best, no matter how healthy they are or need to be.

Each employees' health goals and needs are unique. What's right for one person is not always right for another. Maybe an employee is managing a health condition. Or maybe they want to stay healthy, eat better or get in shape. Whatever the member's needs, Anthem gives you a choice of programs to help you meet personal goals in a way that fits and helps members live their life to the fullest.

Autism Spectrum Disorder Program

Connect with your support team to receive support, knowledge and resources for your whole family.

Case Management

Receive personalized support and care coordination following an illness or hospitalization.

Weight Management Center

Whether you're aiming to lose, gain or maintain, our resources help you navigate your biggest weight challenges.

24/7 NurseLine

Members can speak with a nurse about general health issues any time of the day or night through a convenient toll-free number. 24/7 NurseLine gives your employees access to trained registered nurses who can help in

determining the right care at the right time. In fact, more than 86% of our members rely on advice from our 24/7 NurseLine.[1]

ConditionCare

This comprehensive program can help members with asthma, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD) or diabetes manage their symptoms. ConditionCare is designed to help improve health outcomes for your employees through identification, engagement and support of members living with chronic conditions such as heart disease, diabetes and asthma. The program provides guidance and support to adopt healthier behaviors, 24/7 access to health professionals such as dietitians and nurses, condition-specific education materials and coordination of care.

WebMD Health Risk Assessment

Want to be more energetic? Happier? More balanced? Your assessment is here to help create a plan.

Cancer

No medical jargon here: Access straightforward resources for managing cancer symptoms and treatment.

Live Health Online

Visit virtually with a doctor or licensed therapist to discuss your physical and mental health hurdles.

Tobacco Cessation Center

Motivation, activities and advice to help you reach your goal of quitting tobacco for good.

Digital Future Mom Coaching

The Future Moms program provides expectant moms with individualized support to help them achieve healthier pregnancies and healthier deliveries. Moms-to-be can register for this program and speak to registered nurses about pregnancy issues. The program also includes other prenatal extras like the best-selling book, *Mayo Clinic Guide to a Healthy Pregnancy.* Tools and resources to make your pregnancy and birth journey as smooth as possible.

Preventive Health Guidelines

Stay on top of your recommended screenings and vaccines based on your age and gender.

Diabetes Prevention Program

1 in 3 adults is at risk of developing type 2 diabetes. Lark's Virtual DPP coaching greatly reduces your risk.

Emotional Well-being Resources

Change your mind, change your life. It’s possible with Emotional Well-being Resources, a set of digital tools you can use to help improve your emotional well-being.

Case Management

If members are hospitalized due to an injury or illness, an Anthem case manager is there to help. Our case managers are licensed health professionals who work closely with members to help them understand their benefits and treatment options so they’ll be able to make more informed decisions. The case managers also

help coordinate care and recovery, including finding additional resources and assistance, if needed. For more on these wellness tools and programs, visit our Health & Wellness site.

City Fitness Rooms

Fitness rooms are located at City Hall, the West Yard, the South Yard, the Mabury Yard, the Central Service Yard, the Police Department, and at many Fire Stations. These fitness rooms are designed to offer stretching, weight bearing, and cardio equipment at convenient employee locations. The fitness rooms build on the City's mission to support healthful employee activity and a wellness-focused workplace culture.

Access to fitness rooms is determined by workplace location. For example: The City Hall fitness room is only accessible to City employees assigned to work in the City Hall complex. This does not include off-site employees, contractors, consultants, volunteers, vendors, or unpaid interns. Employees may access the facility via the elevator on the left when they first enter the City Hall Tower building.

Access to the room is granted by using a proximity I.D. badge keyed for City Hall employees through either the Men's or Women's shower/locker rooms. An employee's supervisor may request this access to be added to an employee's I.D. badge. Parking validation cannot be provided to off-site employees if they decide to park at City Hall or pay at the meter on the street.

Use of fitness rooms is allowed during non-paid hours before or after work and during lunch breaks. The following rules apply to the fitness rooms:

- Prior to use, employees are responsible to learn proper exercise techniques, as well as to consult with their medical provider regarding possible health risks.
- Wear appropriate clothing and footwear.
- Act with courtesy and respect toward others using the room or equipment.
- Wipe down equipment after use.
- Non-employee guests are not permitted.
- Report equipment damage immediately to: gs.wo.desk@sanjoseca.gov
- Dial 9-1-1 for emergencies
- FAILURE TO COMPLY WITH THE POSTED RULES MAY LEAD TO A LOSS OF USE PRIVILEGE

SECTION 24: EWAY SELF-SERVICE SYSTEM

eWay is the City's intranet-based employee self-service system that provides employees the opportunity to access, view and update their personal information, certain payroll information, and view and enroll in benefits online. ***eWay*** is a user-friendly and secure system using state-of-the-art technology.

Accessing eWay

1. Login from work or home.
   - **From Work:** https://sjhp92sso.hosted.cherryroad.com/
     - **No need d to sign in separately if you are logged into the City network. eWay has Single Sign On capabilities.**
   - **From Home: https://www.sanjoseca.gov/**
     - **Use Google Chrome for your browser.**
     - Click the **Access eWay** link located at the bottom of the page under **Employees**.
     - **Please note that eWay is not accessible from tablets or mobile devices.**
2. **Enter** your **User ID** and **Password** on the Login screen.
   - User ID = Employee ID # (this is located on the back side of an employee's City ID badge)
   - Temporary Password = First four letters of your last name (1st letter of last name in CAP) +(Last 5 digits of SSN) + (?)

   Examples:

   Tom Smith = Smit51212?
   John Doe = Doe39999?
   Susie Ng: Ng81234?

   Important Password Information
   - **First-time Users:** Change your temporary password the first time you login.
     - ***Changing Your Password***
       - Select "Change My Password" from the menu.
       - Enter your password information. Click "Change Password".
   - Make sure to keep your password confidential.
   - You will be prompted to change your password every 90 days.
3. **Select "Self Service"** and choose from the options below:
   - **Select "Personal Information"** to review/edit your home and mailing address, emergency contacts, email address, and phone number(s).
   - **Select "Payroll and Compensation"** to review your current and prior paychecks; change your tax withholdings; and request a reissue of your W-2 statement. (**See Direct Deposit and Tax Withholding page for more information**).

eWay Password and Network Employee Login Help

If you have access problems, open an IT ticket or contact the **HelpDesk** at (408) 793-6900 or at ithelpishere@sanjoseca.gov. Office hours are Monday - Friday, 7:30 a.m. - 5:30 p.m.

Benefits Enrollment Help

If you need help enrolling in your benefit plans, contact the Human Resources Department at (408) 535-1285 or by email at HRBenefits@sanjoseca.gov.