CITY OF PACIFICA

FINANCING CITY SERVICES TASK FORCE
AGENDA

December 10, 2009
7:00 PM
Pacifica Police Station
2075 Coast Highway

1. Call to Order
2. Approval of 12-3-09 Meeting Minutes
3. Questions from last Meeting
4. Discussion of expenditures
5. Oral Communications/Questions from the Public
6. Next meeting January 14, 2010

City of Pacifica
Financing City Services Taskforce
Minutes – December 3, 2009

1. Call to Order: 7:05 by Vice Chair Mary Ellen Carroll
   Bill Bent, Suzan Getchell-Wallace, Bruce Banco, Sue Vaterlaus, Mary Ellen Carroll, Karen Ervin, Omar Saleh, Mary Ann Nihart, Julie Lancelle and Greg Cochran
   Staff: Steve Rhodes, Ann Ritzma
   Excused: Omar Saleh, Pete Shoemaker

   Audience: None.

2. Approval of Minutes of 11-12-09 – Moved and approved.

3. Questions from Last Meeting – Handout from City Attorney presentation, handout regarding shift in property taxes over the past 10 years and handouts from Steve regarding General Fund and Total Budget Expenditures.

4. Discussion regarding how to approach expenditures and move towards making recommendations. Thoughts:

- Look at both what is long-term and short-term solutions.
- 5-year document will allow taskforce to look at impacts over five years (incrementally) and look towards a healthy reserve in 2014/15.
- Group wanted to hear from each person what their thoughts were today – after all the department presentations. There was interest in discussing labor related costs, prioritizing programs, looking at efficiencies and effectiveness of programs and taking another week to look back over handouts and presentation notes.
- The group decided for the following week to take a target % or $ amount and try to work through that $ amount by identifying possible reductions or savings. Any remaining $ amount that remained after the reductions would become the new $ amount for revenue generation discussion.
- The group decided that working towards a goal would also develop a way to "tell the financial story" when it came time to share with community. The group thought a joint Council/Taskforce meeting would be helpful.

The

5. Next Meeting: December 10, 2009 – Police Department – EOC
   January 14, 2010
   January 28, 2010
   February 11, 2010.

Adjourned at 8:50 pm.

CITY OF PACIFICA
CAFETERIA PLAN BENEFITS FORM
CALENDAR YEAR: 2010

MISCELLANEOUS BARGAINING UNIT

REVISED

NAME

TELEPHONE NUMBER _____

YOUR 2010 SPENDING AMOUNT

BOX A: $

HOW TO USE THIS FORM: The City recognizes that everyone's benefits needs are different. A cafeteria plan allows you to purchase benefits tailored to your needs during a specified period of time. With this IRS approved plan, the City provides you with a monthly dollar amount that you can use to purchase the benefits outlined below. In doing so, you need to plan your benefits needs through December, 2010. The monthly dollar amount that you have to spend will be based upon whether you choose to have Teamsters Health and Welfare benefits or CalPERS medical benefits. Some benefits may have tax consequences, others may not. If you wish to use this amount to pay for medical premiums, use the reverse side of this form to help you determine how much your medical insurance benefits cost. You may use your cafeteria plan to purchase other benefits, as shown below, and an explanation of the various types of benefits available for purchase is described on the reverse. Remember, except under special circumstances, your elections are irrevocable. **PLEASE PLAN THOUGHTFULLY.**

IMPORTANT INFORMATION: IF YOU ARE NOT PURCHASING MONTHLY MEDICAL COVERAGE, YOU MUST ATTACH A CURRENT MEDICAL INSURANCE CARD EVIDENCING COVERAGE THROUGH YOUR SPOUSE/DOMESTIC PARTNER.

☐ **I CHOOSE TO PARTICIPATE IN THE TEAMSTERS MEDICAL PLAN. IN DOING SO, I UNDERSTAND THAT MY MONTHLY BENEFIT AMOUNT IS $1,156.57. THEREFORE, MY ANNUAL AMOUNT IS $1,154.26 x 12 OR $13,878.84. I SHALL PLACE THIS AMOUNT IN BOX A.**

☐ **I CHOOSE TO PARTICIPATE IN CALPERS MEDICAL PLANS. IN DOING SO, I UNDERSTAND THAT MY MONTHLY BENEFIT AMOUNT IS $1,024. THEREFORE, MY ANNUAL AMOUNT IS $1,024 X 12 = OR $12,288. I SHALL PLACE THIS AMOUNT IN THE BOX A.**

☐ **I DO NOT CHOOSE TO PARTICIPATE IN ANY MEDICAL PLANS. ATTACHED IS A COPY OF MY MEDICAL INSURANCE CARD EVIDENCING COVERAGE THROUGH MY SPOUSE/DOMESTIC PARTNER. MY MONTHLY BENEFITS IS $1,024. THEREFORE, MY ANNUAL AMOUNTS IS $1,024 X 12 OR $12,288. I SHALL PLACE THIS AMOUNT IN THE BOX A.**

			ANNUAL TOTALS
1.	MEDICAL INSURANCE PREMIUMS	This is the amount you will spend on medical benefits for this calendar year. Place the total from the reverse side of this page in the column to the right.	$ Box B
2.	MEDICAL EXPENSE REIMBURSEMENT	This is the amount that you want to be reimbursed for medical expenses that are not covered by your medical insurance carrier. Treatment must be provided by a licensed physician and must be medically necessary.	$ Box C
3.	DEPENDENT CARE REIMBURSEMENT	This is for dependent care costs associated with employee's dependent child(ren) provided by a licensed daycare provider or care provided to an elder dependent by a licensed adult care facility as defined by the IRS. Maximum dollar amount is $5,000.	$ Box D
4.	VISION SERVICE PLAN PREMIUMS	Monthly premiums for Vision Service Plan. See attached form.	$ Box E
5.	VACATION PURCHASE (Able to cash out only what has been accrued)	This is for the purchase of additional vacation. Please contact Jill Glander at 650-738-7303 for verification of your hourly salary. You may purchase up to the equivalent of two-weeks' worth of vacation. Formula: _____ x _____ = _____ (hourly rate / hours purchased / dollar total)	$ Box F
6.	CASH TO EMPLOYEE (Can only cash out what you have accrued)	This is the dollar amount you wish to have cashed out. The City will process the cash out in June and December 2010. The maximum amount that you may cash out is the dollar amount that you have accrued up to the cash out date. I wish to cash out this amount in June 2010: _____ I wish to cash out this amount in December 2010: _____	$ Box G
	TOTAL	This represents the total of all your spending accounts. Place the total in the box to the right in box H.	$ Box H
	DO YOU HAVE A CO-PREMIUM?	Box A minus Box H = annual co-pay. Place that negative amount in box I to the right. This amount divided by 12 equals your monthly co-premium that will be collected in the first pay period of every month.	$ Box I

_____ DATE

_____ SIGNATURE

Human Resources Verification: _____

Finance Dept. Verification: _____

2010 MONTHLY PREMIUMS FOR CALPERS MEDICAL PLANS (01-01-2010 thru 12-31-2010)

Plan	Employee Only	Employee Plus One	Employee & Family
BLUE SHIELD	$ 472.33	$1,049.66	$1,396.06
BLUE SHIELD NETVALUE	$ 395.35	$ 895.70	$1,195.91
KAISER	$ 427.56	$ 960.12	$1,279.66
PERS CHOICE	$ 403.74	$ 912.48	$1,217.72
PERS SELECT	$ 369.93	$ 844.86	$1,129.82
PERSCARE	$ 763.17	$1,631.34	$2,152.24
TEAMSTERS HEALTH & WELFARE	$1,290.00	$1,290.00	$1,290.00

2010 ANNUAL PREMIUMS FOR CALPERS MEDICAL PLANS (01-01-2010 thru 12-31-2010)

Plan	Employee Only	Employee Plus One	Employee & Family
BLUE SHIELD	$5,667.96	$12,595.92	$16,752.72
BLUE SHIELD NETVALUE	$4,744.20	$10,748.40	$14,350.92
KAISER	$5,130.72	$11,521.44	$15,355.92
PERS CHOICE	$4,844.88	$10,949.76	$14,612.64
PERS SELECT	$4,439.16	$10,138.32	$13,557.84
PERSCARE	$9,158.04	$19,576.08	$25,826.88
TEAMSTERS HEALTH & WELFARE	$15,480.00	$15,480.00	$15,480.00

MEDICAL INSURANCE PREMIUMS

Rates above reflect a reduction in the overall CalPERS premium cost to employee, as the City pays the required MOU or CalPERS contribution. That contribution, effective 01-01-10, is $105. The tables above provide you with both a monthly premium and an annual premium. If you want to purchase only six months worth of premiums, for example, multiply the monthly premium amount by six. Bring your final TOTAL to **Box B** on the front of this form.

MEDICAL EXPENSE REIMBURSEMENT

You can be reimbursed for expenses not covered by your medical, dental and vision insurance carrier provided that the services you receive are medically required. Reimbursement for health insurance co-premiums, such as one offered by a spouse's employer, is not allowed. Expense must be for employee, spouse, or dependents covered by your insurance plan. Reimbursement requests may be made at any time during the calendar year, but must be for a minimum of $25. Expense **MUST BE SUBMITTED ON A CLAIM FORM AND IT MUST INCLUDE ORIGINAL RECEIPT** (an IRS rule). You must spend the dollar amount indicated for this category by year's end, as **THERE IS NO REIMBURSEMENT FOR UNUSED AMOUNT. Bring your total to Box C.**

DEPENDENT CARE REIMBURSEMENT

Dependent care/child care services must be for employee's dependent(s), as defined by the IRS. Reimbursement requests can be made at any time during this calendar year, but must be for a minimum of $25. Documentation of expense must be submitted with original receipt, and services **MUST BE PROVIDED BY A LICENSED PROFESSIONAL.** Expense must occur during this calendar year. **THERE IS NO REIMBURSEMENT FOR UNUSED AMOUNT. Maximum spending amount is $5,000. Bring your total to Box D.**

VACATION PURCHASE

You may purchase unpaid time off, referred to as purchased vacation. Use your hourly salary as of this past November 1st in calculating this portion. Maximum amount that can be selected is the equivalent of ten (10) vacation days, or a total of 72 hours for fire fighters. If you do not use purchased vacation prior to the end of the calendar year, you will be cashed out, as no portion of this benefit can be carried over to the next fiscal year. A cash out is a taxable event. **Note: *An employee becomes eligible to use purchased vacation only when a participant's regular vacation leave accrual for the Plan Year has been exhausted.* Bring your total to Box F.**

IMPORTANT INFORMATION

All cafeteria plan monies are non-PERSable amounts. Options 1-4 are non-taxable items; options 5-6 are taxable items.

Why enroll in a VSP® Vision Care plan? Because we'll help keep you and your eyes healthy with personalized care from a doctor you can trust.

You'll like what you see with VSP:

- **Personalized Care.** Our doctors take the time to get to know you and your eyes. They'll look for vision problems and signs of other health conditions too.

Doctor Network. You'll find the VSP doctor who's right for you at **vsp.com** or by calling us at **800.877.7195**. Our doctors offer flexible hours, a variety of office settings, and eyewear choices you'll love.

- **Value and Savings.** You'll get great savings on your eye exam and eyewear, and discounts on laser vision correction.
- **Satisfaction Guaranteed.** You'll be 100% happy or we'll make it right.

Enroll today. You'll be glad you did.

Once enrolled, simply tell your VSP doctor you're a member. We'll handle the rest.

Contact VSP

vsp.com
800.877.7195

VSP® Vision care for life

CITY OF PACIFICA and VSP provide you an affordable eyecare plan. Sign up today.

Your Coverage from a VSP Doctor

WellVision Exam® focuses on your eye health and overall wellness

- $10.00 copay.....***every 12 months***

Prescription Glasses

- $25.00 copay

Lenses.....***every 12 months***

- *Single vision, lined bifocal and lined trifocal lenses.*
- *Polycarbonate lenses for dependent children.*

Frame..... ***every 12 months***

- *$130 allowance for frame of your choice.*
- *20% off amount over your allowance*

~OR~

Contact Lens Care

No copay applies.....**every 12 months**

$130.00 allowance for contacts and the contact lens exam (fitting and evaluation).
Current soft contact lens wearers may be eligible for a special program that includes an initial contact lens evaluation and initial supply of lenses.

Your Contribution

Employee Only	**$17.42 Monthly**
Employee + One Dependent	**$25.26 Monthly**
Employee + Family	**$45.29 Monthly**

Extra Discounts and Savings

Glasses and Sunglasses
•Average 35 - 40% savings on all non-covered lens options
•30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam

Contacts
•15% off cost of contact lens exam (fitting and evaluation)

Laser Vision Correction
•Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.
•After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

If you see a non-VSP provider, you'll receive a lesser benefit. Before seeing a non-VSP provider, call us at 800.877.7195 for more details.

Out-of-Network Reimbursement Amounts:

Exam	*Up to $ 45.00*
Single Vision Lenses	*Up to $ 45.00*
Lined Bifocal Lenses	*Up to $ 65.00*
Lined Trifocal Lenses	*Up to $ 85.00*
Frame	*Up to $ 47.00*
Contacts	*Up to $ 105.00*

VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

11/08 CAT#01947 JOB#203CM