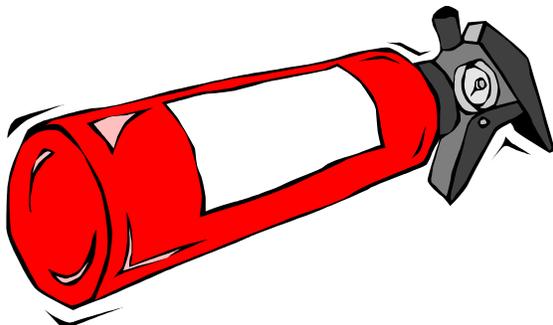


HBFA

Huntington Beach Fire Association



MEDICAL PLAN COMPARISONS FOR ELIGIBLE HBFA CITY EMPLOYEES AND DEPENDENTS		
BENEFIT	IN NETWORK	OUT OF NETWORK
Annual Deductible	<i>\$0 Single \$0 Family</i>	<i>\$500 Single \$1,000 Family</i>
Choice of Providers	Your Choice. Higher benefits paid with In Network Providers	Your Choice. High benefits paid with In Network Providers
Office Visits	\$10 visit	30%
Preventative Care	\$10 visit	Not covered
Inpatient Hospital Facility Charges	10%	30%
Inpatient Professional Services & Anesthetics	10%	30%
Outpatient Surgery	10%	30%
Prescriptions: Retail Pharmacy 30-day supply	\$5 Generic \$15 Formulary \$30 Brand	25% of allowable plus: \$5 Generic \$15 Formulary \$30 Brand
Mail Service 90-day supply	\$10 Generic \$25 Formulary \$45 Brand	Not Covered
Durable Medical Equipment & Prosthetics	10%	30%
Mental Health: Inpatient Outpatient	10% \$25 visit	30%
Annual Out-of-Pocket Maximum	<i>\$2,000 Single \$4,000 Family</i>	<i>\$5,000 Single \$10,000 Family</i>
Monthly cost of plan:		
Employee Only	\$386.74	
Employee + 1	\$762.59	
Employee + 2 or more	\$1013.22	
EMPLOYEE COST SHARING		
	Per Pay Period	Annual
Employee Only	\$ 5.98	\$ 155.48
Employee + 1	\$27.85	\$ 724.10
Employee + 2 or more	\$74.71	\$1,942.46

MEDICAL PLAN COMPARISONS FOR ELIGIBLE CITY EMPLOYEES AND DEPENDENTS

BENEFIT	BLUE SHIELD PPO - HIGH OPTION		BLUE SHIELD PPO - LOW OPTION	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Annual Deductible	\$500 Single \$1,000 Family		\$500 Single \$1,000 Family	
Choice of Providers	Your Choice Higher benefits paid with In Network Providers.		Your Choice Higher benefits paid with In Network Providers.	
Office Visits	\$20 visit	40%	\$20 visit	40%
Preventative Care	No Charge	40%	No Charge	40%
Inpatient Hospital Facility Charges	10%	40%	20%	40%
Emergency Services Ambulance	\$50 (waived if admitted) + 10% 20%		\$50 (waived if admitted) + 20% 20%	
Inpatient Professional Services, Surgery & Anesthetics	10%	40%	20%	40%
Outpatient Surgery	10%	40%	20%	40%
Prescriptions Retail Pharmacy 30-day Supply	\$5 Generic \$15 Formulary \$30 Brand Name	25% of allowable amount, plus: \$5 Generic \$15 Formulary \$30 Brand Name	\$5 Generic \$15 Formulary \$30 Brand Name	25% of allowable amount, plus: \$5 Generic \$15 Formulary \$30 Brand Name
Mail Service 90-day Supply	\$10 Generic \$25 Formulary 45 Brand Name	Not Covered	\$10 Generic \$25 Formulary \$45 Brand Name	Not Covered
Durable Medical Equipment & Prosthetics	10% (Orthoses up to \$2,000/person/year maximum)	40%	20% (Up to \$2,000/person/year maximum)	40%
Mental Health Services				
Inpatient	10%	40%	20%	40%
Outpatient	\$20 visit	40%	\$20 visit	40%
Annual Out-of-Pocket Maximum	\$2,000 Single \$4,000 Family	\$10,000 Single \$20,000 Family	\$3,000 Single \$6,000 Family	\$10,000 Single \$20,000 Family
Monthly cost of plan:				
Employee Only	\$ 533.10		\$ 398.19	
Employee + 1	\$1,152.49		\$ 841.91	
Employee + 2 or more	\$1,495.47		\$1,043.26	
EMPLOYEE COST SHARING				
	Per Pay Period	Annual	Per Pay Period	Annual
Employee Only	\$ 73.56	\$1,911.96	\$11.27	\$ 293.04
Employee + 1	\$ 207.80	\$5,402.88	\$64.46	\$1,675.92
Employee + 2 or more	\$297.29	\$7,729.56	\$88.58	\$2,303.04

MEDICAL PLAN COMPARISONS FOR ELIGIBLE CITY EMPLOYEES AND DEPENDENTS

BENEFIT	BLUE SHIELD HMO		KAISER HMO	
Annual Deductible	<i>None</i>		<i>None</i>	
Choice of Providers	Blue Shield HMO Providers Only		Kaiser HMO Providers Only	
Office Visits	\$10 visit		\$10 visit	
Preventative Care	\$10 visit		See Summary of Benefits	
Inpatient Hospital Facility Charges	No Charge		No Charge (requires pre-authorization)	
Emergency Services	\$25 visit (waived if admitted)		\$50 visit (waived if admitted)	
Ambulance	No Charge		No Charge (for true emergency)	
Inpatient Professional Services, Surgery & Anesthetics	No Charge		No Charge (requires pre-authorization)	
Outpatient Surgery	No Charge		\$10 procedure	
Retail Pharmacy 30-day Supply	\$5 Generic \$15 Formulary \$30 Brand Name		\$5 Generic \$15 Brand Name (Up To 100 Day Supply)	
Mail Service 90-day Supply	\$10 Generic \$25 Formulary \$45 Brand Name		(Certain drugs covered at 50%; Refer to formulary guidelines)	
Durable Medical Equipment & Prosthetics	No Charge		No Charge	
Mental Health Service	No Charge		No Charge	
Inpatient	No Charge		No Charge	
Outpatient	\$10 visit		\$10 visit	
Annual Out-of-Pocket Maximum	<i>\$1,000 Single</i> <i>\$2,000 Family</i>		<i>\$1,500 Single</i> <i>\$3,000 Family</i>	
Monthly cost of plan:				
Employee Only	\$302.52		\$263.77	
Employee + 1	\$659.00		\$577.66	
Employee + 2 or more	\$853.54		\$759.67	
EMPLOYEE COST SHARING				
	Per Pay Period		Annual	
	Per Pay Period		Annual	
Employee Only	\$13.15	\$ 341.88	\$ 0.00	\$ 0.00
Employee + 1	\$47.76	\$1,241.88	\$10.22	\$285.80
Employee + 2 or more	\$61.55	\$1,600.32	\$18.23	\$473.88

DELTA DENTAL PLAN COMPARISON FOR ELIGIBLE EMPLOYEES AND DEPENDENTS

BENEFIT	DELTA PREFERRED OPTION (DPO)		DELTA CARE (PMI)
Choice of Providers	A DPO IN-NETWORK DENTIST	AN OUT-OF-NETWORK DENTIST	Pre-selected PMI dentists only
Annual Deductible	<i>Deductible waived on Diagnostic & Preventative</i>	<i>\$25 Single \$75 Family per calendar year</i>	<i>None</i>
Annual Maximum	<i>\$2,000</i>	<i>\$2,000</i>	<i>None</i>
Diagnostic & Preventive <ul style="list-style-type: none"> • Oral exams • X-rays • Cleanings 	85% of DPO approved fee	85% of Delta approved fee	No charge for covered services
Basic <ul style="list-style-type: none"> • Oral surgery • Fillings • Root Canals • Gingivectomy 	85% of DPO approved fee	85% of Delta approved fee	No charge for covered services
Major <ul style="list-style-type: none"> • Crowns, Jackets, Inlays, Onlays 	85% of DPO approved fee	85% of Delta approved fee	No charge for covered services
Major <ul style="list-style-type: none"> • Bridges • Dentures 	60% of DPO approved fee (denture subject to a maximum allowance)	60% of Delta approved fee (denture subject to a maximum allowance)	No charge for covered services
Orthodontia	60% <i>\$3,000 Lifetime maximum benefit</i>	60% <i>\$3,000 Lifetime maximum benefit</i>	\$500 Copay + start up fees for normal 24 month treatment
Dependent Children	Eligible to age 19 or age 25 if full-time student and unmarried		
Monthly cost of plan:			
Employee Only	\$ 61.67		\$ 24.87
Employee + 1	\$ 115.16		\$ 38.16
Employee + 2 or more	\$ 151.78		\$ 58.32

EMPLOYEE COST SHARING

	Per Pay Period	Annual	Per Pay Period	Annual
Employee Only	\$ 8.67	\$225.48	\$.86	\$22.44
Employee + 1	\$15.39	\$400.08	\$1.47	\$38.16
Employee + 2 or more	\$16.35	\$425.04	\$2.24	\$58.32

VISION SERVICE PLAN (VSP) FOR ELIGIBLE EMPLOYEES AND DEPENDENTS

EMPLOYEE COST SHARING

	Monthly cost of plan:	Per Pay Period	Annual	BENEFIT
Employee Only	\$22.81	\$2.41	\$62.86	When using a VSP provider: \$10 Copay for exam, lenses, frames and contact lenses* once every 12 months. Benefits are also available from non-network providers but your out-of-pocket costs will be greater. Please see plan brochure for further information. (Dependent children are eligible to age 19 or age 25 if full-time student and unmarried) *Contact lenses are in lieu of spectacle lenses and frame
Employee + 1	\$22.81	\$2.41	\$62.86	
Employee + 2 or more	\$22.81	\$2.41	\$62.86	

HBFA GROUP LIFE INSURANCE

PAID BY THE CITY <i>Assurant Insurance</i>	\$50,000 benefit
PAID BY THE CITY Dependent Coverage <i>Assurant Insurance</i>	Up to \$1,500 benefit (spouse and each child) (Please refer to your Certificate of Coverage)
PAID BY THE EMPLOYEE Optional Group Universal Life: <i>Principal Financial Group</i> or <i>ING Benefits</i> AND Critical Illness Insurance: <i>ING Benefits</i>	You may purchase these insurances for yourself and your dependents. Please refer to the plan brochure for rates and information. Please note that with the exception of new hires, all other employees will be responsible for, but not necessarily limited to, any underwriting charges associated with their application (i.e. diagnostic testing and examinations).

HBFA ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (AD&D)

PAID BY THE CITY <i>Assurant Insurance</i>	\$50,000 benefit						
PAID BY THE EMPLOYEE <i>Assurant Insurance</i>	Additional Benefit Amount					Your cost per paycheck	
	Employee	Spouse	Child(ren)	Spouse Only	Child(ren) Only	Employee	Family
	\$25,000	\$12,500	\$2,500	\$15,000	\$3,750	\$0.53	\$0.75
	\$50,000	\$25,000	\$5,000	\$30,000	\$7,500	\$1.05	\$1.50
	\$100,000	\$50,000	\$10,000	\$60,000	\$16,000	\$2.10	\$3.00
You may select either "Employee" or "Family" plan. The family plan includes coverage for you, your spouse and child(ren), if any.							

HBFA LONG TERM DISABILITY INSURANCE (LTD)

PAID BY THE CITY	Helps to provide you income when you are disabled and cannot work. Administered by the Huntington Beach Firefighters' Association. Please see your association representative for complete details.
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OTHER IMPORTANT INFORMATION ABOUT YOUR COVERAGES

1. **When does my coverage start?** Your medical, dental and vision coverage begins on the first of the month following your hire date. City paid life, AD&D and LTD begin on your date of employment. Optional life and AD&D begin the first of the month following your enrollment and/or approval by the insurance carrier.
2. **COBRA** At the time you terminate employment with the City, you have sixty (60) days to exercise your right to continue group medical, dental and/or vision coverage under COBRA. Certain other events are also covered under COBRA. Please review the COBRA Notice you received with your new hire packet.
3. **Benefits subject to change** as the result of the meet and confer process and, in the case of minor modifications, as mandated by the insurance carrier(s).
4. **Ineligible dependents** You will be held financially responsible for premiums for dependents not removed from all plans when such dependent becomes ineligible for coverage's as determined by the specific plan document.
5. **Section 125 Plan** Employee contributions will be deducted on a pre-tax basis under the City's IRC Section 125 plan. Employees may elect to participate in a pre-tax savings account for unreimbursed medical and/or childcare expenses. Please refer to the plan's Summary Plan Description for important plan rules. All contributions to the pre-tax spending account must be used in the year they are deducted. Federal law does not allow monies to be carried over to the following year.
6. **Disclaimer** The information provided in this brochure is a comparison of select benefits only and serves as a summary of coverage's for your association. The plan documents take precedence over any discrepancies. Benefits are subject to change as the result of the meet and confer process and, in the case of minor modifications, as mandated by the insurance carrier(s). For detailed information about any of the benefits of our plan(s), your rights, obligations or privileges under the plan(s), please refer to the plan documents, the insurance carrier or Employee Benefits Division of Human Resources.