

PMA

Huntington Beach Police Management Association



**2006 BRIEF SUMMARY OF PORAC BENEFITS
(The Prudent Buyer Plan®)**

Prudent Buyer Calendar Year Deductible: <i>\$300 per member / \$900 per family</i> Non-Prudent Buyer Calendar Year Deductible: <i>\$600 per member / \$1,800 per family</i>		Maximum Out-of-Pocket Costs: \$3,000 per member or \$6,000 per family (does not apply to mental disorders & chemical dependency treatment, or Rx drugs)	
		Prudent Buyer Plan Providers	Non-Prudent Buyer Plan Providers*
Physician Care	Office visits Home & hospital visits, obstetrical care, surgery Allergy testing, serum injections & medication Well-child care up to \$500/year (includes immunizations & inoculations)	\$20 copay 10% 10% No charge No charge	10%* 10%* 10%* No charge* No charge*
Hospital Services Inpatient Outpatient	Semi-private room/board & all medically necessary care Surgical room, renal dialysis	10% 10%	10%* 10%*
Prescription Drugs	Drugs prescribed by a physician (drugs include birth control pills, insulin & authorized diabetic supplies)	Retail: Generic: \$10 copay Brand: \$25 copay Non-Formulary: \$45 copay Mail Order: Generic: \$20 copay Brand: \$30 copay Non-Formulary \$75 copay	Retail Limited Fee Schedule Limited Fee Schedule Limited Fee Schedule Mail Order: Not Covered
Emergency Services	In- and out-of-area for the initial treatment of a sudden & severe illness or accidental injury;	10%	10%
Physical Therapy & Chiropractic Care	All services	10%	10% (up to \$700/year)
Diagnostic X-Ray/Lab	Outpatient diagnostic X-ray & lab services	10%	10%
Mental Disorders & Substance Abuse	COMPREHENSIVE BEHAVIORAL HEALTH PROGRAM		
Durable Medical Equipment & Supplies	Certified by a physician & required for the care of an illness or injury;	20%	20%

Monthly cost of plan:

Employee Only	\$399.00
Employee + 1	\$748.00
Employee + 2 or more	\$950.00

EMPLOYEE COST SHARING

Per Pay Period

Annual

WITH VISION COVERAGE		
Employee Only	\$11.64	\$ 302.64
Employee + 1	\$21.12	\$ 549.12
Employee + 2 or more	\$45.54	\$1,184.04
WITHOUT VISION COVERAGE		
Employee Only	\$ 1.17	\$ 29.04
Employee + 1	\$10.58	\$275.28
Employee + 2 or more	\$35.01	\$910.20

2006 CALPERS BASIC PLAN COMPARISON				
BENEFIT	PERS CHOICE PPO		PERS CARE PPO	
	PPO	NON-PPO	PPO	NON-PPO
CALENDAR YEAR DEDUCTIBLE (Not transferable between plans)	\$500 Single \$1,000 Family		\$500 Single \$1,000 Family	
HOSPITAL ADMISSION DEDUCTIBLE Per Admission	None	None	\$250	\$250
EMERGENCY ROOM DEDUCTIBLE/COPAY Per visit (waived if admitted to hospital as inpatient or for observation as outpatient)	\$50	\$50	\$50	\$50
MAXIMUM CALENDAR YEAR COPAY Single Family	\$3,000 \$6,000	None None	\$2,000 \$4,000	None None
Hospital-In-Patient and Outpatient	20%	40%	10%	40%
Physician Office Visits	\$20 copay	40%	\$20 copay	40%
Other Physician Services	20%	40%	10%	40%
Preventive Care	No charge	40%	No charge	40%
Diagnostic X-ray and Laboratory	20%	40%	10%	40%
Emergency Services	20%	20%	10%	10%
	(\$50 deductible per vision for covered ER charges – waived if admitted to hospital)			
Chiropractic	20%	40%	10%	40%
	(Combined benefit for Chiropractic / Acupuncture—15 visits per calendar year)		(Combined benefit for Chiropractic / Acupuncture—20 visits per calendar year)	
Durable Medical Equipment	20%	40%	10%	40%
	(3,000 per calendar year—precertification required)		(Precertification required)	
Mental Health (Includes mental health parity provisions) Inpatient	20%	40%	10%	40%
	(Up to 20 days per calendar year)		(Up to 30 days per calendar year—\$12,000 lifetime maximum for any combination of inpatient and outpatient benefits)	
Mental Health (Includes mental health parity provisions) Outpatient	20%	40%	10%	40%
	(Up to 24 visits per calendar year for other than severe mental illness or serious emotional disturbance of a child—precertification required for licensed clinical psychologists and master's level therapists only)		(Up to 30 visits per calendar year for other than severe mental illness or serious emotional disturbance of a child—precertification required for licensed clinical psychologists and master's level therapists only)	
PRESCRIPTION DRUG BENEFITS				
Retail Pharmacy PERS CHOICE: Up to a 30-day supply for short-term use PERS CARE: Up to a 34-day supply for a short-term use	\$ 5 Generic \$15 Formulary Brand \$45 Non-Formulary Brand (\$30 if medical necessity approved for non-formulary)		\$ 5 Generic \$15 Formulary Brand \$45 Non-Formulary Brand (\$30 if medical necessity approved for non-formulary)	
Mail Service Up to a 90-day supply	\$10 Generic \$25 Formulary Brand \$75 Non-Formulary Brand (\$45 if medical necessity approved for non-formulary)		\$10 Generic \$25 Formulary Brand \$75 Non-Formulary Brand (\$45 if medical necessity approved for non-formulary)	
Monthly cost of plan:				
Employee Only	\$384.56		\$ 646.74	
Employee + 1	\$769.12		\$1,293.48	
Employee + 2 or more	\$999.86		\$1,681.52	
EMPLOYEE COST SHARING				
	Per Pay Period	Annual	Per Pay Period	Annual
WITH VISION COVERAGE				
Employee Only	\$ 4.98	\$ 129.48	\$125.99	\$3,275.74
Employee + 1	\$30.86	\$ 802.36	\$272.88	\$7,094.88
Employee + 2 or more	\$68.55	\$1,782.30	\$383.16	\$9,962.16
WITHOUT VISION COVERAGE				
Employee Only	\$.00	\$.00	\$115.46	\$3,001.92
Employee + 1	\$20.34	\$ 528.72	\$262.34	\$6,821.04
Employee + 2 or more	\$58.02	\$1,508.52	\$372.63	\$9,688.44

2006 CALPERS BASIC PLAN COMPARISON				
BENEFIT	BLUE SHIELD HMO		KAISER PERMANENTE	
CALENDAR YEAR DEDUCTIBLE	None Single None Family		\$1,500 Single \$3,000 Family	
HOSPITAL ADMISSION DEDUCTIBLE Per Admission	No Charge		No Charge	
EMERGENCY ROOM DEDUCTIBLE/COPAY Per visit (waived if admitted to hospital as inpatient or for observation as outpatient)	\$50		\$50	
MAXIMUM CALENDAR YEAR COPAY Single Family	None None		None None	
Hospital-In-Patient and Outpatient	No Charge		No Charge	
Physician Office Visits	\$10 visit (\$30 visit for specialists if self-referred)		\$10 visit	
Preventive Care	\$10 visit/immunization		\$10 visit	
Diagnostic X-ray and Laboratory	No Charge		No Charge	
Emergency Services (Waived if admitted to hospital)	\$50 visit		\$50 visit	
Chiropractic	Not covered		\$10 visit (Up to 20 visits per calendar year)	
Durable Medical Equipment	No Charge		No Charge (In accord with DME formulary guidelines)	
Mental Health (Includes mental health parity provisions) Inpatient	No Charge (Up to 30 days per calendar year—no limits for severe mental illness or serious emotional disturbances of a child)		No Charge (Up to 30 days per calendar year—Limits do not apply to certain mental health conditions)	
Mental Health (Includes mental health parity provisions) Outpatient	\$20 visit (Up to 20 visits per calendar year for other than severe mental illness or serious emotional disturbance of a child) \$10 visit (No limits for severe mental illness or serious emotional disturbances of a child)		\$10 per individual visit \$5 per group visit (These visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as describe in the "Benefits, Copayments, and Coinsurance" section)	
PRESCRIPTION DRUG BENEFITS				
Retail Pharmacy	30-day supply \$ 5 Generic \$15 Formulary Brand \$45 Non-Formulary Brand ((\$30 if medical necessity approved for non-formulary)		Up to a 100-day supply \$ 5 Generic \$15 Formulary Brand	
Mail Service Up to a 90-day supply	\$10 Generic \$25 Formulary Brand \$75 Non-Formulary Brand ((\$45 if medical necessity approved for non-formulary)		\$10 Generic \$25 Formulary Brand \$75 Non-Formulary Brand ((\$45 if medical necessity approved for non-formulary)	
Monthly cost of plan:				
Employee Only	\$357.67		\$320.55	
Employee + 1	\$715.34		\$641.10	
Employee + 2 or more	\$929.94		\$833.43	
EMPLOYEE COST SHARING				
	Per Pay Period		Annual	
WITH VISION COVERAGE				
Employee Only	\$38.60		\$1,003.60	
Employee + 1	\$73.77		\$1,918.02	
Employee + 2 or more	\$96.81		\$2,517.06	
WITHOUT VISION COVERAGE				
Employee Only	\$28.07		\$ 729.96	
Employee + 1	\$63.24		\$1,644.24	
Employee + 2 or more	\$86.28		\$2,243.40	

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		\$ 42.29
Employee + 2 or more	\$ 151.78		\$ 64.67

EMPLOYEE COST SHARING

	<i>Per Pay Period</i>	<i>Annual</i>	<i>Per Pay Period</i>	<i>Annual</i>
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 BENEFIT

	Monthly cost of plan:	Per Pay Period	Annual	
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	\$62.96	
Employee + 2 or more	\$22.81	\$2.41	\$62.86	

PMA GROUP LIFE INSURANCE

PAID BY THE CITY <i>Assurant Insurance</i>	\$50,000 benefit
PAID BY THE EMPLOYEE Additional Group Life <i>Assurant Insurance</i>	<p style="text-align: center;">\$25,000 benefit</p> <p>You may purchase additional group life insurance for yourself. Evidence of good health is required if application is made after the first 31 days of employment. Late enrollment is subject to approval by the insurance carrier.</p> <p style="text-align: center;">Your cost per paycheck is \$8.75</p>
PAID BY THE EMPLOYEE Optional Group Universal Life Principal Financial Group or ING Benefits AND Critical Illness Insurance ING Benefits	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).

PMA 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.							

PMA LONG TERM DISABILITY INSURANCE (LTD)

PAID BY THE CITY <i>Assurant Insurance</i>	Helps to provide you income when you are disabled and cannot work. Benefits begin on the 61 st day of disability. Pays 66 2/3% of your base pay to a maximum of \$12,500 monthly. Certain other benefits will reduce your LTD payment (PERS, Workers' Comp., etc.) Benefits can continue up to 2 years for illness or pregnancy (age 65 for accidents). Please see your certificate of coverage for complete details and policy exclusions.
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OTHER IMPORTANT INFORMATION ABOUT YOUR COVERAGES

- 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.
- 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.
- 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).
- Ineligible dependents** You will be held financially responsible for premiums for dependents not removed from all plans when such dependent becomes ineligible for coverages as determined by the specific plan document.
- 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.
- 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.