Surf City…

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TO BETTER HEALTH

Your Benefits 2016

POA/PMA/MSMA/FMA/HBFA

Medical Open Enrollment Period: September 14th to October 9th

All Other Benefit Plans Open Enrollment Period: October 1st to October 30th

(Dental, Vision, FSA, Supplemental Life/AD&D)

If you (and/or your dependent) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 20-21 for details.

SUMMARY

The information in this brochure is a general outline of the benefits offered under the City of Huntington Beach's benefits program. Specific details and plan limitations are provided in the Evidence of Coverage (EOC), which is based on the official Plan Documents that may include policies, contracts and plan procedures.

The EOC and Plan Documents contain all the specific provisions of the plans. In the event that information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

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EMPLOYEE BENEFITS PROGRAM 1/1/2016 THRU 12/31/2016

INTRODUCTION

The City of Huntington Beach takes pride in offering a Benefit Program that provides flexibility for the diverse and changing needs of our employees. The City offers employees and their family members a full range of benefits including:

- Medical HMO Plans
- Medical PPO Plans
- Dental HMO Plan
- Dental PPO Plan
- Vision Plan
- Basic Life and AD&D Plan
- Long-Term Disability Plan
- Supplemental Life and AD&D Plan
- Flexible Spending Account (FSA)
- Employee Assistance Program (EAP)

The Human Resources Department has taken many steps in providing easy access to health and benefit plan information. Please visit the City's intranet site, SurfNet, to view the Employee Benefits link in the Human Resources section or visit the City's internet site at www.huntingtonbeachca.gov/employee_benefits. Here you will find access to plan information, forms, contact information and more. Human Resources will continue to update SurfNet with employee benefit information, so check back often!

If you have any questions, please do not hesitate to call our Employee Benefits Team:
Barbara Pratt, Personnel Assistant, (714) 375-8456
Jaymie Liu, Human Resources Analyst, (714) 536-5213 or
Brigitte Charles, Principal Human Resources Analyst, (714) 536-5917

Sincerely,

Michele S. Warren
Director of Human Resources

WHAT YOU NEED TO KNOW

Human Resources would like to take this opportunity to give you important information about the benefits being offered by the City of Huntington Beach for the 2016 calendar year. The California Public Employees Retirement System (CalPERS) has mailed Open Enrollment packets that include a personalized Health Plan Statement, an Open Enrollment newsletter and information on how to request additional information. It is important that you use the following information to educate yourself about the open enrollment process, timeline and changes.

What can I do at this year's Open Enrollment?

City of Huntington Beach benefit-eligible employees can:

- Enroll/make changes to **Medical, Dental, Vision, Voluntary Life (with evidence of insurability) and Accidental Death & Dismemberment (AD&D) Plans**
- Add or delete dependents in the City's Medical, Dental, Vision, Voluntary Life and AD&D plans
- Switch to a different Medical or Dental plan
- Participate in and determine the amount for flexible spending accounts
- Change your life insurance beneficiary

What do I have to do if I am NOT making changes?

- Even if you are not making any changes, you need to indicate "no changes" on your Confirmation Statement for 2016 and verify the accuracy of personal data, especially social security numbers for dependents. **Also, if you are interested in establishing a 2016 flexible spending account, you must enroll/re-enroll**. Complete an EBS enrollment form and return to Human Resources/Employee Benefits by 5:00 p.m., Friday, October 30, 2015 for your 2016 plan year election(s).

How do I participate in Open Enrollment?

- Submit all changes, **via a hard copy of your Confirmation Statement summary to Human Resources**. Your benefit elections will be effective January 1, 2016. You can obtain Flexible Spending Account, Supplemental Life and AD&D Insurance forms and beneficiary designations through SurfNet or at www.huntingtonbeachca.gov/employee_benefits. **All changes must be received by Human Resources no later than 5:00 p.m. on Friday, October 30, 2015.**

- For any changes to CalPERS medical elections, you **must also submit them directly to HR by October 9, 2015** on an HBD12 form which is available at www.calpers.ca.gov and make the change on your Confirmation Statement. **Note: Open enrollment for CalPERS is September 14, 2015 through October 9, 2015 ONLY**.

What if I have questions or need assistance?

- Call or e-mail:
  Barbara Pratt at (714) 375-8456, bpratt@surfcity-hb.org
  Jaymie Liu at (714) 536-5213, jaymie.liu@surfcity-hb.org
  Brigitte Charles at (714) 536-5917, bcharles@surfcity-hb.org

  Note: Employee benefits staff are available for enrollment assistance.

(Continued on next page)

WHAT YOU NEED TO KNOW (Cont'd)

What if I want to make changes throughout the year?

- You can only make changes outside of Open Enrollment if you have a Qualifying Event.

  To add dependents you have **31 days** from the Qualifying Event to submit an "Add Dependent" form to Human Resources. The Qualifying Event could be marriage, birth, adoption, a dependent becoming eligible, spouse losing coverage, etc.

- You are required to submit a "Delete Dependent" form to Human Resources within 30 days of a dependent becoming ineligible such as divorce, an overage dependent no longer eligible, etc. **Failure to do so can jeopardize your COBRA rights.**

- The above-mentioned forms are available on SurfNet/Human Resources/Employee Benefits and on the Lower Level of City Hall on the Employee Benefits Information Wall Display.

WHAT WILL HAPPEN ON JANUARY 1, 2016

What will be the same on January 1, 2016?

- Benefit Carriers for Medical, Dental, Vision and EAP will remain the same.

What will change on January 1, 2016?

- The FSA limit will increase to $2,550 for healthcare expenses.

- Employee contributions will change.

- **Rate sheets will be posted on SurfNet/Human Resources/Employee Benefits/2016 Health Premiums and Contributions**.

ELIGIBILITY

You are eligible for the ***City of Huntington Beach's Medical Program*** if you are a permanent employee working 20 or more hours per week. Your effective date is the first day of the month following your date of hire.

After your initial benefit enrollment, you cannot make changes in your elections or terminate coverage until the next Open Enrollment period, unless you qualify for a "special enrollment." Please refer to the "Rules For Benefit Changes During The Year" section on the next page for special enrollment qualifications. To terminate coverage, you must contact Human Resources/Employee Benefits.

Dependent Eligibility

- Your legal spouse
- Your registered domestic partner
- Your natural children, stepchildren, and/or adopted children of which the employee is the legal guardian, legally placed with the employee or eligible domestic partner for adoption, or supported pursuant to a court order imposed on the employee or eligible domestic partner (including a qualified medical child support order). In addition:
  - ⇒ For Medical/Dental/Vision Insurance: Dependents are eligible up to the end of the month in which they turn age 26
- Your eligible physically or mentally handicapped children who depend on you for support, regardless of age.

Your dependent's effective date is on the latest of 1) your effective date, or 2) the first of the month following the date you acquire your dependent.

Adding and Excluding Dependents

Newly acquired dependents may be added to the plan during the year by completing the necessary forms within **31 days** of their eligibility. If you do not add dependents within the 31-day period and do not qualify for a "special enrollment" (see the next page), they will not be eligible to enroll until the next Open Enrollment period.

RULES FOR BENEFIT CHANGES DURING THE YEAR

Other than during annual open enrollment, you may only make changes to your benefit elections if you experience a qualified status change or qualify for a "special enrollment". If you qualify for a mid-year benefit change, you will be required to submit proof of the change or evidence of prior coverage.

Qualified Status Changes include:

- **Change in legal marital status**, including marriage, divorce, legal separation, annulment, and death of a spouse.
- **Change in number of dependents**, including birth, adoption, placement for adoption, or death of a dependent child.
- **Change in employment status that affects benefit eligibility**, including the start or termination of employment by you, your spouse, or your dependent child.
- **Change in work schedule**, including an 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 place of residence or worksite**, in which the change affects the accessibility of network providers.
- **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.
- **An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA)** including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan.
- **An event that is allowed under the Children's Health Insurance Program Reauthorization Act (CHIPRA).** Under provisions of the Act, employees have 60 days after the following events to request enrollment if:
  - Employee or dependent loses eligibility for Medicaid (known as Medi-Cal in CA) or CHIP (known as Healthy Families in CA).
  - Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP.

Two rules apply when making changes to your benefits during the year:

- Any change you make must be consistent with the change in status, AND
- You must make the change within 31 days of the date the event occurs (unless otherwise noted above).

MEDICAL PROGRAM BENEFITS

The ***City of Huntington Beach's*** goal is to provide you with affordable, quality health care benefits. Our medical benefits are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. The City of Huntington Beach offers a choice of medical plans through **CalPERS**.

- **HMO (Health Maintenance Organization)** – The HMO plans offer comprehensive coverage. Care is provided or coordinated through each member's Primary Care Physician (PCP). **You have a choice in Orange County between the Anthem Blue Cross Select HMO, Anthem Blue Cross Traditional HMO, Blue Shield Access+ HMO, Blue Shield NetValue, HealthNet Salud y Más, HealthNet SmartCare, Kaiser and the UnitedHealthcare Alliance HMO plan.**

- **PPO (Preferred Provider Organization)** – The PPO plan is designed to provide choice--two levels of service, flexibility and value. Participants have a choice of using Preferred Providers (PPO provider) or going directly to any other physician (non-PPO provider) without a referral. Generally, there are annual deductibles to meet before benefits apply. You are also responsible for a certain percentage of the charges (co-insurance), and the plan pays the balance up to the agreed upon amount. **You have an option between the PERS Select, PERS Choice, PERSCare and PORAC plans.**

- **Medical Opt-Out Benefit** – Employees who are covered by another group medical program outside of a City sponsored plan or are covered as a dependent under a spouse's or domestic partner's plan through the City and elect to opt out of the medical coverage will receive a cash benefit. See SurfNet for the 2016 rate sheets. **Note: This benefit is included as taxable income**. Proof of outside coverage is required and must be on file annually in the Human Resources Office.

MEDICAL PLAN FEATURES

	HMO OPTIONS SCHEDULE OF BENEFITS	
	PERS BLUE SHIELD HMO & NET VALUE HMO*	PERS KAISER HMO
PLAN BENEFITS		
OFFICE VISITS	$15 Copay	$15 Copay
PRESCRIPTION DRUG (must use a participating pharmacy)	(not to exceed 90-day supply) $5 Generic $20 Brand $50 Non-Formulary	(not to exceed 30-day supply) $5 Generic $20 Brand
PRESCRIPTION DRUG - MAIL ORDER**	(not to exceed 90-day supply)** $10 Generic /$40 Brand $100 Non-Formulary	(31-100 day supply) $10 Generic/$40 Brand
EMERGENCY SERVICES	$50 Copay (waived if admitted as an inpatient or for observation as an outpatient)	$50 Copay (waived if admitted as an inpatient or for observation as an outpatient)
DEDUCTIBLE	None	None
MAXIMUM OUT-OF POCKET Individual Family	 $1,500 $3,000	 $1,500 $3,000
LIFETIME MAXIMUM	Unlimited	Unlimited
ROUTINE PHYSICAL EXAMS	No Charge	No Charge
CHIROPRACTIC	Not Covered	Not Covered
VISION EXAM	No Charge	No Charge
HOSPITAL SERVICES Inpatient Outpatient	 No Charge No Charge (exceptions may apply)	 No Charge $15/Visit
OUTPATIENT LAB & X-RAY	No Charge	No Charge
SUBSTANCE ABUSE PROGRAM Inpatient Outpatient	 No Charge $15 Copay	 No Charge $15 Copay
MENTAL HEALTH Inpatient Outpatient	See EOC	See EOC

*The Blue Shield NetValue plan benefits mirror the Blue Shield HMO plan; however, NetValue offers Blue Shield's "high performance network", only available in certain counties.
**For Blue Shield PrimeMail information, visit www.MyPrimeMail.com.

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MEDICAL PLAN FEATURES

	HMO OPTIONS SCHEDULE OF BENEFITS	
	PERS ANTHEM BLUE CROSS SELECT HMO & TRADITIONAL HMO	PERS HEALTH NET SALUD Y MÁS & SMARTCARE
PLAN BENEFITS		
OFFICE VISITS	$15 Copay	$15 Copay
PRESCRIPTION DRUG (must use a participating pharmacy)	(not to exceed 30-day supply) $5 Generic $20 Brand $50 Non-Formulary	(not to exceed 30-day supply) $5 Generic $20 Brand $50 Non-Formulary
PRESCRIPTION DRUG - MAIL ORDER	(not to exceed 90-day supply) $10 Generic $40 Brand $100 Non-Formulary	(not to exceed 90-day supply) $10 Generic $40 Brand $100 Non-Formulary
EMERGENCY SERVICES	$50 Copay (waived if admitted as an inpatient or for observation as an outpatient)	$50 Copay (waived if admitted as an inpatient or for observation as an outpatient)
DEDUCTIBLE	None	None
MAXIMUM OUT-OF POCKET Individual Family	 $1,500 $3,000	 $1,500 $3,000
LIFETIME MAXIMUM	Unlimited	Unlimited
ROUTINE PHYSICAL EXAMS	No Charge	No Charge
CHIROPRACTIC	Not Covered	Not Covered
VISION EXAM	No Charge	No Charge
HOSPITAL SERVICES Inpatient Outpatient	 No Charge No Charge	 No Charge No Charge
OUTPATIENT LAB & X-RAY	No Charge	No Charge
SUBSTANCE ABUSE PROGRAM Inpatient Outpatient	 No Charge $15 Copay	 No Charge $15 Copay
MENTAL HEALTH Inpatient Outpatient	See EOC	See EOC

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MEDICAL PLAN FEATURES

	HMO OPTIONS SCHEDULE OF BENEFITS
	PERS UNITEDHEALTHCARE ALLIANCE HMO
PLAN BENEFITS	
OFFICE VISITS	$15 Copay
PRESCRIPTION DRUG (must use a participating pharmacy)	(not to exceed 90-day supply) $5 Generic $20 Brand $50 Non-Formulary
PRESCRIPTION DRUG - MAIL ORDER	(not to exceed 90-day supply) $10 Generic $40 Brand $100 Non-Formulary
EMERGENCY SERVICES	$50 Copay (waived if admitted as an inpatient or for observation as an outpatient)
DEDUCTIBLE	None
MAXIMUM OUT-OF POCKET Individual Family	 $1,500 $3,000
LIFETIME MAXIMUM	Unlimited
ROUTINE PHYSICAL EXAMS	No Charge
CHIROPRACTIC	Not Covered
VISION EXAM	No Charge
HOSPITAL SERVICES Inpatient Outpatient	 No Charge No Charge
OUTPATIENT LAB & X-RAY	No Charge
SUBSTANCE ABUSE PROGRAM Inpatient Outpatient	 No Charge $15 Copay
MENTAL HEALTH Inpatient Outpatient	 See EOC

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MEDICAL PLAN FEATURES

	PERS CHOICE & SELECT* LOW OPTION PPO		PERS CARE* HIGH OPTION PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
PLAN BENEFITS				
OFFICE VISITS	$20 Copay	40%	$20 Copay	40%
PRESCRIPTION DRUG Retail Pharmacy	(not to exceed 30-day supply) $5 Generic $20 Brand $50 Non-Formulary		(not to exceed 34-day supply) $5 Generic $20 Brand $50 Non-Formulary	
Retail Pharmacy – Maintenance Drugs after 2nd Fill	(not to exceed 30-day supply) $10 Generic $40 Brand $100 Non-Formulary		(not to exceed 34-day supply) $10 Generic $40 Brand $100 Non-Formulary	
PRESCRIPTION DRUG - MAIL ORDER	(not to exceed 90-day supply) $10 Generic $40 Brand $100 Non-Formulary		(not to exceed 90-day supply) $10 Generic $40 Brand $100 Non-Formulary	
EMERGENCY SERVICES	$50 + 20% ($50 deductible waived if admitted as an inpatient or for observation as an outpatient)		$50 + 10% ($50 deductible waived if admitted as an inpatient or for observation as an outpatient)	
DEDUCTIBLE Individual Family	$500 $1,000		$500 $1,000	
MAXIMUM OUT-OF-POCKET Individual Family	$3,000 $6,000	N/A	$2,000 $4,000	N/A
LIFETIME MAXIMUM	Unlimited		Unlimited	
DURABLE MEDICAL EQUIPMENT	20%	40%	10%	40%
	Pre-certification required for equipment		Pre-certification required for equipment priced at $1,000 or more	
CHIROPRACTIC/ACUPUNCTURE	20%	40%	10%	40%
	(15 visits per year combined)		(20 visits per year combined)	
INPATIENT HOSPITAL SERVICES	20%[1]	40%	$250 / Admit + 10%	$250 / Admit + 40%
OUTPATIENT LAB & X-RAY	20%	40%	10%	40%
SUBSTANCE ABUSE PROGRAM Inpatient Outpatient	20%	40%	10%	40%
MENTAL HEALTH Inpatient Outpatient	See EOC		See EOC	

1. Inpatient Hospital Services under PERS Select Plan can be 20-30% (in-network) depending on the hospital.

*PERS Select utilizes the Anthem Blue Cross Select PPO Network, which is a subset of the Anthem Blue Cross Prudent Buyer PPO Network. Approximately 50% of the Anthem Prudent Buyer PPO Network of physicians participate in the Select PPO Network. By obtaining physician services through the Select PPO Network, you will receive the highest level of reimbursement. PERS Choice and PERSCare utilize the Anthem Bule Cross Prudent Buyer PPO Network, which is a more comprehensive network. By obtaining physician services through Anthem Prudent Buyer PPO Network, you will receive the highest level of reimbursement.

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MEDICAL PLAN FEATURES

	PORAC ANTHEM BLUE CROSS PPO	
	PPO IN-NETWORK	NON-PPO OUT-OF-NETWORK
PLAN BENEFITS		
OFFICE VISITS	$20 Copay (deductible does not apply)	10%
PRESCRIPTION DRUG (30-day supply)	$10 Generic $25 Brand $45 Non-Formulary / Compound	$10 Generic $25 Brand $45 Non-Formulary / Compound
PRESCRIPTION DRUG - MAIL ORDER (90-day supply)	$20 Generic $40 Brand $75 Non-Formulary	N/A
EMERGENCY SERVICES	10%	
DEDUCTIBLE Individual Family	$300 $900	$600 $1,800
MAXIMUM OUT-OF-POCKET Individual Family (combined PPO and Non-PPO)	$3,000 $6,000	$3,000 $6,000
LIFETIME MAXIMUM	Unlimited	
DURABLE MEDICAL EQUIPMENT	20%	20%
CHIROPRACTIC	$20 / Visit Up to 20 Visits	$35 / Visit
ACUPUNCTURE	$20 (10% for all other services)	10%
HOSPITAL SERVICES	10%	10%
OUTPATIENT LAB & X-RAY	10%	10%
SUBSTANCE ABUSE PROGRAM Inpatient Outpatient	10%	10%
MENTAL HEALTH Inpatient Outpatient	See EOC	See EOC

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DENTAL PLAN FEATURES

	DELTA DENTAL DENTAL PPO			DELTA DENTAL DENTAL HMO**
	IN-NETWORK	OUT-OF-NETWORK		IN-NETWORK ONLY
	PPO DENTISTS	NON-PPO DELTA DENTISTS	NON-DELTA DENTISTS*	
PLAN BENEFITS				
ANNUAL MAXIMUM	$2,000 max. benefit			Unlimited
DEDUCTIBLE Individual Family	$25 per person / $75 per family			None
PREVENTIVE Exams X-Rays Cleanings Fluoride Treatment Space Maintainers	85% of PPO dentist's allowed fee (no deductible applies for these services)	85% of Delta dentist's allowed fee		No Charge
BASIC SERVICES Basic Restorative Endodontics Periodontics Sealants Simple Extractions	85% of PPO dentist's allowed fee	85% of Delta dentist's allowed fee		No Charge
MAJOR SERVICES Inlays, Onlays, Crowns	85% of PPO dentist's allowed fee	85% of Delta dentist's allowed fee		No Charge
Prosthodontics	60% of PPO dentist's allowed fee	60% of Delta dentist's allowed fee		$0 - $50
Implants	60% of PPO dentist's allowed fee	60% of Delta dentist's allowed fee		Not Applicable
ORTHODONTIA	Adult & Child 60% of PPO dentist's allowed fee (subject to $3000 lifetime max per person)	Adult & Child 60% of Delta dentist's allowed fee (subject to $3000 lifetime max per person)		Adult & Child: $500 + startup for normal 24 month treatment

*Members will be responsible for the difference if non-Delta dentists charge more than Delta's allowed fees.
** Consult the full benefit description for a complete listing of basic covered services, costs for treatment upgrades, and any limitations and exclusions.

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VISION PLAN FEATURES

	VISION SERVICE PLAN (VSP) VISION	
	IN-NETWORK	OUT-OF-NETWORK
PLAN BENEFITS		
COPAY	$15	
FREQUENCY Examination Frame Lenses Contact Lenses (in lieu of lenses)	Every 12 months Every 12 months Every 12 months Every 12 months	
EXAM *(Dilation when necessary)*	Covered in full*	$50 Allowance
STANDARD LENSES Single Vision Bifocal Trifocal	Covered in full*	$50 Allowance $75 Allowance $100 Allowance
FRAMES	$120 Allowance	$70 Allowance
LASER VISION CORRECTION (US LASER NETWORK)	Discounts at participating facilities	N/A
CONTACT LENSES: Elective Medically Necessary	$120 Allowance Covered in full	$105 Allowance $210 Allowance

*Vision exam is covered once every 12 months at the $15 copay. If a member requires lenses and has already paid the $15 exam copay, then an additional $15 is not required.

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BASIC LONG-TERM DISABILITY (LTD)

MSMA/FMA: When non-work related illness or injury make it impossible for you to work for an extended period of time, eligible employees' income may be continued under the City of Huntington Beach's ***Basic LTD plan***. The City of Huntington Beach pays the entire cost of coverage. Under the plan, if you are disabled for more than 30 days, (60 days for MSMA employees) you could receive a benefit of 67% of your basic monthly pay (up to $12,500 per month) until you are able to return to work.

POA/PMA/HBFA: The City contributes towards a long-term disability plan provided by the Police Officers' Association and by the Huntington Beach Firefighters Association.

BASIC LIFE AND AD&D

Life insurance provides protection for your beneficiary in the event of your death. All full-time employees automatically receive ***Basic Life and Accidental Death & Dismemberment (AD&D) Insurance*** coverage. The benefit amount is $50,000.

SUPPLEMENTAL LIFE AND AD&D

The Voluntary (employee-paid) Life coverage through Cigna Group Insurance allows employees the option to purchase from $10,000 to $500,000 in $10,000 increments. This coverage is also available to spouses and may be purchased even if the employee does not enroll (however, the Spouse amount may not exceed 100% of the employees Basic and Additional Life combined). There is also coverage available for dependent children. If it is your open enrollment period and you did not enroll when you were first eligible, or if you are currently enrolled in supplemental life insurance and you wish to increase your current coverage, you will need to complete and submit an *Evidence of Insurability* form and be approved by underwriting before the policy goes into effect. The effective date of any pending voluntary Life/AD&D elections will be the date your coverage is approved; however, your premium will not begin until the first of the month following the date your coverage is approved.

The Voluntary (employee paid) AD&D coverage allows members the option to purchase $25,000 or $50,000 or $100,000. There is also coverage available for spouses and dependent children, as a percentage of the employee's principal amount.

Please see the summary sheet for more information that is available online on SurfNet or through Human Resources.

FLEXIBLE SPENDING ACCOUNT (FSA)

The Flexible Spending Account (FSA) lets you pay some of your health care and dependent care expenses and reduce your taxable income at the same time. You can set up one FSA for health care expenses and another to pay for the cost of caring for your dependents while you are at work. The FSA allows you to use pre-tax dollars to pay for eligible expenses that are not reimbursed by another medical, dental and/or vision plan or tax credit. Such expenses include medical and dental deductibles, coinsurance, copayments, prescription glasses, contact lenses, LASIK eye surgery, and child/elder care expenses.

When you set up an FSA, you place money in your account through automatic, pre-tax payroll deductions. Then, as you incur eligible health care or dependent care expenses, you are reimbursed tax-free from your account. You pay no federal income taxes, no Social Security taxes, and no state income taxes on the amount of pre-tax dollars you contribute to an FSA or on the reimbursements you receive.

If ineligible expenses are submitted for reimbursement, you will be required to reimburse the plan.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The EAP program (employer-paid) is a service designed to help you manage life's challenges. Everyone needs a helping hand once in a while, and your EAP can provide it. The EAP can refer you to professional counselors and services that can help you resolve emotional, health, family and work issues. The service is available 24 hours a day, 7 days a week. This service provides 5 counseling sessions per member per incident.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

Your plan offers a choice of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. If you are not clear about any of the bolded terms used in the SBC, you can view the glossary at www.cciio.cms.gov or see Human Resources to obtain a copy.

Please see Human Resources if you have questions or would like a copy of an SBC or a glossary of terms.

Notice of Availability of HIPAA Privacy Notice

The Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we periodically remind you of your right to receive a copy of the HIPAA Privacy Notice. You can request a copy of the Privacy Notice by contacting Human Resources. HIPAA Privacy Notices that pertain to the plans may be obtained by contacting your insurance carrier directly.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**GEORGIA – Medicaid**
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300

SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/ programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/ programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/ pages/ index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid% 20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

These benefits are subject to the same deductible and co-payments applicable to other medical and surgical benefits provided under this plan. You can contact your health plan's Member Services for more information.

NOTICE OF SPECIAL ENROLLMEN RIGHTS FOR MEDICAL/HEALTH PLAN COVERAGE

If you decline enrollment in an City of Huntington Beach health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in an City of Huntington Beach health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.

- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in an City of Huntington Beach medical plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Important Notice from City of Huntington Beach About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. City of Huntington Beach has determined that the prescription drug coverage offered by the plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your City of Huntington Beach coverage may be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under City of Huntington Beach is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your City of Huntington Beach prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

(Continued on next page)

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

You should also know that if you drop or lose your current coverage with City of Huntington Beach and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Huntington Beach changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2016
Name of Entity:	City of Huntington Beach
Contact:	Human Resources
Address:	2000 Main Street, Huntington Beach, CA 92648
Phone Number:	(714) 375-8456

HELPFUL TIPS TO SAVE YOU TIME AND MONEY

Where can I get Additional Information on the CalPERS Medical Options?

Visit the CalPERS website at www.calpers.ca.gov. There is a special section on Open Enrollment with links to useful information and publications.

Prevention is the Best Medicine

- All employees and family members should be receiving the preventive services recommended for their age and gender.
- Everyone with chronic conditions (hypertension, asthma, diabetes, etc.) needs to follow all recommended care prescribed by your physician.

My Dental Bills are Painful!

Dental bills can add up very quickly. If you are having dental work that will cost you more than $200, ask the dentist to get pre-authorization prior to the service. The insurance company will notify you if the procedure will be covered, how much *they* will pay, and how much *you* will be responsible to pay.

I Need HELP with My Insurance

Contact the customer service group for the appropriate carrier in the "Employee Benefits Contact Information" Section or visit the City's internet site at www.huntingtonbeachca.gov/employee_benefits.

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EMPLOYEE BENEFITS CONTACT INFORMATION

Human Resources – Employee Benefits

- Intranet: http://surfnet/Human_Resources/
- Phone: (714) 375-8456
  (714) 536-5213
  (714) 536-5917
- Fax: (714) 374-1743
- Email: bpratt@surfcity-hb.org
  jaymie.liu@surfcity-hb.org
  bcharles@surfcity-hb.org
- Internet: www.surfcity-hb.org/employee_benefits

CalPERS Retirement

- www.calpers.ca.gov
- (Group #0097)
  (888) 225-7377 or (888) CAL-PERS

PARS Retirement (Part-Time Employees)

- www.parsinfo.org
  (800) 540-6369

CalPERS Medical (POA, PMA, MSMA, FMA, HBFA)

- www.calpers.ca.gov
  (888) 225-7377 or (888) CAL-PERS
- CalPERS Anthem Blue Cross Select HMO
  (855) 839-4524
- CalPERS Anthem Blue Cross Traditional HMO
  (855) 839-4524
- CalPERS Blue Shield Access+ (Group #PH0001)
- (800) 334-5847
- CalPERS Blue Shield NetValue (Group #PH0010)
  (800) 334-5847
- CalPERS HealthNet Salud y Más
  (888) 926-4921
- CalPERS HealthNet SmartCare
  (888) 926-4921
- CalPERS Kaiser HMO (Group #105705-00)
  (800) 464-4000
- CalPERS UnitedHealthcare Alliance HMO
  (877) 359-3714
- CalPERS Anthem Blue Cross - PERS Select (Group #SB050A)
  (877) 737-7776
- CalPERS Anthem Blue Cross - PERS Choice (Group #CB050A)
  (877) 737-7776
- CalPERS Anthem Blue Cross - PERS Care (Group #KB050A)
  (877) 737-7776
- CalPERS Anthem Blue Cross PORAC (Group #13079)
  (800) 288-6928

Dental

- www.deltadentalins.com
- Delta Dental PPO (Group #4729)
  (888) 335-8227
- Delta Care HMO (Group #1575)
  (800) 422-4234

Vision

- www.vsp.com
- (Group # 00105162)
  (800) 877-7195

Cigna Life and Disability

- www.cigna.com
  (800) 362-4462
- Life and Voluntary Life (Group # FLX965003)
- AD&D and Voluntary AD&D (Group # OK966605)
- Disability (Group # LK963478)

EBS Flexible Spending (FSA)

- Internet: www.ebsbenefits.com
- Phone: (888) 327-2770
- Fax: (925) 460-3929
- Email: customerservice@ebsbenefits.com
- Flex Card: www.ebsbenefits.com
- Address:
  P.O. Box 11657
  Pleasanton, CA 94588

MHN-(Employee Assistance Program)

- www.members.mhn.com
- access code: huntingtonbch
  (800) 242-6220

Due to privacy issues and concerns, we strongly recommend contacting your insurance provider directly with regard to claims, replacement/lost cards, or coverage questions.

Employee Benefits Brochure designed and developed by

Alliant EMPLOYEE BENEFITS

in conjunction with the City of Huntington Beach, September 2015