Surf City…

…Catch the Wave

TO BETTER HEALTH

Your Benefits 2012

MEA/MEO/NA

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 17-18 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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WHAT YOU NEED TO KNOW

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

- Medical HMO Plans
- Medical PPO Plan
- Medical PPO HDHP Plan (High Deductible Health Plan)
- 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 City's Blue Shield medical plans will continue to be administered through CSAC-EIA. There will be some changes to the current Blue Shield HMO (impacting the Emergency Room co-pay) and PPO plan (impacting the Office Visit and ER copay and Lab &X-Ray). **Blue Shield HMO pharmacy benefits will now be administered by Medco** and Blue Shield PPO pharmacy benefits will continue to be administered by Medco. There will also be a new plan offering to the employees, a High Deductible Health Plan (HDHP).

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. Carr
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 2012 calendar year. It is important that you use the following information to educate yourself about the open enrollment process, timeline and changes. The Open Enrollment period is from October 3, 2011 to 5:00 p.m., November 4, 2011.

In addition an Educational Forum has been scheduled for Tuesday, October 18, 2011 in the City Council Chambers from 9:00 a.m. to 11:00 a.m. During this time, carrier representatives will provide an overview of plan components.

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 2012 (Confirmation Statement) and verify the accuracy of personal data, especially social security numbers for dependents. **Also, if you are interested in establishing a 2012 flexible spending account, you must enroll/re-enroll**. Complete a TRI-AD enrollment form and return to Human Resources/Employee Benefits by 5:00 p.m. Friday, November 4, 2011 for your 2012 plan year election(s).

How do I participate in Open Enrollment?

- Submit all changes **via a hard copy of your confirmation statement to Human Resources**. Your benefit elections will be effective January 1, 2012. 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, November 4, 2011.**

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 60 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, 2012

What will be the same on January 1, 2012?

- Benefit Carriers for all plans will remain the same.

What will change on January 1, 2012?

- New option Blue Shield PPO HDHP Plan (High Deductible Health Plan)

- Employee contributions will change.

- Magellan Behavioral Health (Magellan) will replace Mental Health Service Administrator (MHSA) as the mental health administrator for Blue Shield.

- As of January 1, 2012, members on the *Blue Shield HMO* plan will receive a separate pharmacy card from Medco. You will no longer be able to obtain prescriptions with your Blue Shield ID card. Remember to give your pharmacist the new Medco information when you have a new prescription or are getting a refill. Mail Order prescriptions will also use Medco. **You will need to contact your doctor and request that he send Medco a new prescription for your maintenance medications. Blue Shield cannot transfer your prescription to Medco.**

- **Rate sheets will be posted on SurfNet/Human Resources/Employee Benefits/2012 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 insurance: Dependents are eligible up to age 26
  - ⇒ For Dental/Vision Insurance: Unmarried dependents are eligible up to age 25.
- 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 may 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 (CHIP) Reauthorization Act.** 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 **Blue Shield and Kaiser Permanente**.

- **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 between the Blue Shield HMO and the Kaiser 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.

- **HDHP (High Deductible Health Plan)** – The HDHP plan provides choice and two levels of service: in -network and out-of-network. The HDHP plan uses the same network of providers as the PPO plan design. This plan has a higher annual deductible that must be met before it begins to pay the appropriate co-insurance amount. This includes Pharmacy Benefits which require the deductible to be met before the co-pays listed will apply. The Preventive Care benefits are covered at no charge regardless of deductible being met.
    - **HSA (Health Savings Account)** – An HSA is available to you if you are enrolled in a HDHP plan. An HSA allows you to contribute pre-tax dollars to your account, with the balance accumulating year to year, if not spent. HSA funds can be used to pay any qualified medical expenses. This type of Health Savings Account is owned by you and is portable. If you decide to terminate the HDHP plan, you will no longer be able to deposit new funds into the HSA account, but funds already in the HSA will remain available for your use.

- **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 2012 rate sheets. **Note: This benefit is included as taxable income**. Proof of outside coverage is required and must be on file in the Human Resources Office.

PRESCRIPTION DRUG PROGRAM BENEFITS

Employees who are enrolled in a Blue Shield HMO plan will now have their prescription drug coverage through Medco. Employees who are enrolled in the Blue Shield PPO and HSA plans will have prescription drug coverage through Medco. All of the plans offer access to a vast number of retail pharmacies. Retail pharmacies can be used if you are taking a drug on a short-term basis.

If you are taking prescription medications on a regular basis, you may save time and money by using a mail order pharmacy. Members save on out-of-pocket copay costs, and shipping is free for standard postal delivery. Blue Shield HMO members can now also use Medco by Mail as their mail service pharmacy by calling (800) 711-0917. Blue Shield PPO and HDHP members can also use Medco by Mail by calling (800) 711-0917. Please refer to the schedule of benefits in this brochure for more information.

HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account is available to employees who participate in the Blue Shield High Deductible Health Plan (HDHP).

How a HSA Works

- A HSA is a bank account that works in conjunction with an HDHP. A HSA is an employee owned bank account that can be used to help pay for qualified medical expenses such as office visits, hospital stay, prescription drugs, etc.
- The HSA moves with you if you ever change employers, and funds in the HSA roll-over year-to-year. A HSA is **not** a 'use-it-or-lose-it' plan.
- You elect how much you want to contribute to your HSA each pay period, up to the IRS maximum. The funds are deducted, before taxes are withheld, in increments, or as a lump sum, from your pay.
- You can elect to change your HSA payroll deduction at anytime throughout the year, as long as your annual contribution remains under the IRS limits.
- If you and your spouse are both enrolled in a HDHP and contribute into a HSA, your combined HSA contribution cannot be more than the 2012 IRS maximum, even if your spouse does not work for the City of Huntington Beach.
- When you have an eligible expense, simply use your HSA debit card to pay for the expense. Your HSA account balance must be greater than or equal to the total expense amount, otherwise your transaction will be denied.
- Funds in your HSA can be used to pay for qualified medical expenses of **IRS tax dependents**, even if the dependent is not enrolled in your HDHP.
- You are not eligible to elect a HSA if you are a Medicare member or if an employee is claimed as a dependent on another's tax return.
- If you enroll in a HSA and a healthcare FSA, you are only eligible to use the healthcare FSA for dental and vision expenses.

HSA Contribution Limits for 2012

The IRS has set the contribution limits for the 2012 tax year as set forth below:

Annual Single Contribution Maximum	$3,100
Annual Family Contribution Maximum	$6,250
Annual Catch-up Contribution Maximum	$1,000 (for HSA participants that are 55 years and older.)

For more information on how to open a HSA account, or to make any changes to your contribution amount through the years, please contact Human Resources at (714) 375-8456.

MEDICAL PLAN FEATURES

	HMO OPTIONS SCHEDULE OF BENEFITS	
	BLUE SHIELD HMO	KAISER HMO
PLAN BENEFITS		
OFFICE VISITS	$15 Copay $30 Copay for self-referred specialist consultation	$15 Copay
PRESCRIPTION DRUG (must use a participating retail pharmacy)	(Up to a 30-day supply) $10 Generic $25 Brand $45 Non-Formulary	(30-day supply) $10 Generic $20 Brand
PRESCRIPTION DRUG (Medco)* MAIL ORDER	(up to a 90-day supply)* $20 Generic $50 Brand $90 Non-Formulary	(100-day Supply) $20 Generic $40 Brand
EMERGENCY SERVICES	$200 Copay (waived if admitted)	$100 Copay (waived if admitted)
DEDUCTIBLE	None	None
MAXIMUM OUT-OF-POCKET Individual Family	$1,000 $2,000	$1,500 $3,000
LIFETIME MAXIMUM	Unlimited	Unlimited
ROUTINE PHYSICAL EXAMS	No Charge	$15 Copay
CHIROPRACTIC	Not Covered	$10 Copay (30 visits/calendar year)
VISION EXAM	No Charge	$15 Copay ($150 hardware allowance/24 months)
HOSPITAL SERVICES Inpatient Outpatient	$100/Admit No Charge	No Charge $15 per Procedure
OUTPATIENT LAB & X-RAY	No Charge	No Charge
SUBSTANCE ABUSE PROGRAM Inpatient Outpatient	$100/Admit (detox only) $15 Copay	No Charge (detox only) $15 Copay Individual / $5 Group
MENTAL HEALTH Inpatient Outpatient	See EOC	See EOC

*For Medco information visit www.Medco.com

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MEDICAL PLAN FEATURES

	BLUE SHIELD PPO PLAN	
	IN-NETWORK	OUT-OF-NETWORK
PLAN BENEFITS		
OFFICE VISITS/SPECIALIST VISIT	$30 Copay/$50 Copay	40%
PRESCRIPTION DRUG (Medco)* (up to a 30-day supply)	$10 Generic $20 Brand (**$100 Brand Deductible per Member)** $50 Non-Formulary	Plan pays 100% of the allowable amount. Member pays copay (below), plus charges above allowable amount. $10 Generic $20 Brand (**$100 brand deductible per member)** $50 Non-Formulary
PRESCRIPTION DRUG (Medco)* MAIL ORDER (up to a 90-day supply)	$20 Generic $40 Brand (**$100 Brand Deductible per Member)** $100 Non-Formulary	Not Covered
EMERGENCY SERVICES	$200 / Visit + 20% ($200 deductible waived if admitted)	
DEDUCTIBLE Individual Family	$750 $1,500	$1,000 $2,000
MAXIMUM OUT-OF-POCKET Individual Family	$3,000 $6,000	$10,000 $20,000
LIFETIME MAXIMUM	Unlimited	
DURABLE MEDICAL EQUIPMENT	20%	40%
CHIROPRACTIC	20%	40%
	(15 visits per year combined with Acupuncture)	
HOSPITAL SERVICES Inpatient Outpatient	20% 20%	40% (Max $600/Day) 40% (Max $350/Day)
OUTPATIENT LAB & X-RAY	$30/Visit	40%
SUBSTANCE ABUSE PROGRAM Inpatient Outpatient	20% $25/Visit	40% (Max $600/Day) 40%
MENTAL HEALTH Inpatient Outpatient	See EOC	See EOC

*For Medco information, visit www.Medco.com.

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MEDICAL PLAN FEATURES

	BLUE SHIELD HDHP PLAN	
	IN-NETWORK	OUT-OF-NETWORK
PLAN BENEFITS		
OFFICE VISITS	20%	50%
PRESCRIPTION DRUG (Medco)* (up to a 30-day supply)	In-Network plan deductible must be met before Rx copayments apply $10 Generic $20 Brand $50 Non-Formulary	In-Network plan deductible must be met before Rx copayments apply $10 Generic $20 Brand $50 Non-Formulary
PRESCRIPTION DRUG (Medco)* MAIL ORDER (up to a 90-day supply)	In-Network plan deductible must be met before Rx copayments apply $20 Generic $40 Brand $100 Non-Formulary	Not Covered
EMERGENCY SERVICES	$100 / Visit + 20% (deductible waived if admitted)	
DEDUCTIBLE** Individual Family	$1,250 $2,500	$1,250 $2,500
MAXIMUM OUT-OF-POCKET Individual Family	$5,000 $10,000	$5,000 $10,000
LIFETIME MAXIMUM	Unlimited	
DURABLE MEDICAL EQUIPMENT	20%	50%
CHIROPRACTIC	20%	50%
	(15 visits per year combined with Acupuncture)	
HOSPITAL SERVICES Inpatient Outpatient	20% 20%	50% (Max $600/Day) 50% (Max $350/Day)
OUTPATIENT LAB & X-RAY	20%	50%
SUBSTANCE ABUSE PROGRAM Inpatient Outpatient	20%	50%
MENTAL HEALTH Inpatient Outpatient	See EOC	See EOC

*For Medco information, visit www.Medco.com.

** Deductible accumulates toward the out of pocket maximum

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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		No Charge
Implants	60% of PPO dentist's allowed fee	60% of Delta dentist's allowed fee		Not Applicable
ORTHODONTIA	60% of PPO dentist's allowed fee (subject to $3000 lifetime max per person)	60% of Delta dentist's allowed fee (subject to $3000 lifetime max per person)		$500 copay + startup for normal 24 month treatment

*Members will be responsible for the difference if non-Delta dentists charge more than Delta's allowed fees.

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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*	$45 Allowance
STANDARD LENSES Single Vision Bifocal Trifocal	Covered in full*	$45 Allowance $65 Allowance $85 Allowance
FRAMES	$120 Allowance	$47 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)

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, you could receive a benefit of 66 2/3% of your basic monthly pay (up to $12,500 per month) until you are able to return to work.

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 Standard Insurance Company 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; however, the employee must also be enrolled for supplemental coverage. 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.

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.

HEALTH CARE REFORM

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) DISCLOSURE STATEMENT

This group health plan believes the Kaiser Permanente HMO Health Plan is considered a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (714) 536-5917. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA) OF 2009

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in California, you may be eligible for assistance paying your employer health plan premiums. This information is current as of January 31, 2011. You should contact your State for further information on eligibility–

CALIFORNIA—MEDICAID
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 866-298-8443

If you live outside of California, please contact either 877-KIDS-NOW or visit www.insurekidsnow.gov to find your State's information.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act (WHCRA) requires employer groups to notify participants and beneficiaries of the group health plan, of their rights to mastectomy benefits under the plan. Participants and beneficiaries have rights to coverage to be provided in a manner determined in consultation with the attending Physician 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.

(Continued on next page)

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Your medical benefit plan may impose a preexisting condition exclusion upon enrollees age 19 and older. That means that if you are age 19 or older and have a medical condition before coming to our Plan, you might have to wait a certain period of time before the Plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period. Generally, this 6 month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 6 month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy.

This exclusion may last up to 12 months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days.

To reduce the exclusion period by your creditable coverage, you should provide the new carrier with a copy of any certificates of creditable coverage (HIPAA Certificates) you have. If you do not have a Certificate, but you do have prior health coverage, you can obtain one from your prior plan or issuer.

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.

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 and 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. The City of Huntington Beach has determined that the prescription drug coverage offered by the plan 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 through 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 and drop your current City of Huntington Beach prescription drug coverage, be aware that you and your dependents will not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

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.

(Continued on next page)

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

Contact the office listed below for further information. NOTE: You'll 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 City of Huntington Beach changes. You also may request a copy of this notice at any time.

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

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll 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, 2012
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

Take Advantage of the Mail Order Pharmacy Benefit! Why go to the pharmacy if you don't have to?

Employees who are enrolled in the Blue Shield plans will have prescription drug coverage through Medco.

If you are taking prescription medications on a regular basis, you may save time and money by using a mail order pharmacy. You may be able to receive a 90-day supply for two co-payments and your prescription is mailed directly to your home. Members save on out-of-pocket copay costs and shipping is free for standard postal delivery. Blue Shield plan members can use Medco by Mail by calling (800) 711-0917 or visiting their website at www.medco.com.

Having Surgery and/or X-Rays this Year?

If you are on the PPO plan, remember to ask your doctor if you are being referred to a Blue Shield -In-Network facility. Out of network hospitalizations are only covered at 60%, and Blue Shield pays a maximum of $350 per day (out-patient) or $600 per day (in-patient). As always, verify that your surgery and/or x-ray has been pre-authorized by Blue Shield prior to your surgery and/or x-ray.

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.

EMPLOYEE BENEFITS CONTACT INFORMATION

Human Resources – Employee Benefits

- Intranet: http://surfnet/Human_Resources/Employee Benefits
- Phone: (714) 375-8456, (714) 536-5213 or (714) 536-5917
- Fax: (714) 374-1743
- Email: bpratt@surfcity-hb.org
  jaymie.liu@surfcity-hb.org
  bcharles@surfcity-hb.org
- Internet: www.huntingtonbeachca.gov/employee_ benefits

CalPERS Retirement

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

Blue Shield (MEA, MEO, NA)

- www.blueshieldca.com/csac
- HMO Medical (Group #EH1009)
  (800) 642-6155
- PPO Medical (Group #E10055)
  (800) 642-6155
- PPO Medical HDHP (Group # E10075)
  (800) 642-6155
- Rx through Medco Pharmacy (All Medical Plans)
  (800) 711-0917
- Wells Fargo (HSA Bank)
  (866) 884-7374

PARS Retirement (Part-Time Employees)

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

Kaiser (MEA, MEO, NA)

- www.kaiserpermanente.org
- (Group #227450)
  (800) 464-4000

Dental

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

Vision

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

Standard Life and Disability

- www.standard.com
- Life/AD&D (Group #148463)
- Voluntary Life/AD&D (Group #148463)
  (800) 628-8600
- Disability (Group # 148463)
  (800) 368-1135

TRI-AD Flexible Spending (FSA)

- www.tri-ad.com
- www.mbicard.com (Flexcard)
  (800) 733-7555

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

in conjunction with the City of Huntington Beach, October 2011