Surf City…

…Catch the Wave

TO BETTER HEALTH

Your Benefits 2010

Medical Open Enrollment Period: September 14 to October 9, 2009
Dental and Vision Open Enrollment Period: October 12 to November 20, 2009

POA/PMA/MSOA/FMA

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 page 13 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 1/1/2010 THRU 12/31/2010

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 Plan (EAP)

This year's Open Enrollment period is focused on educating employees on the best options to meet their needs while promoting health and wellness. The PERS Health Fair for PEMCHA medical plans is scheduled in the Police Training Classroom A on Thursday, October 1. We encourage your attendance in order to meet with benefit plan representatives and participate in complimentary health screenings. In addition, the City will be hosting an Open Enrollment informational meeting on Wednesday, October 14 from 9:30 a.m. to 11:30 a.m. in the Council Chambers.

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.surfcity-hb.org/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 2010 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?

- This year the City is holding a Passive Open Enrollment. If you are not making any changes, you do not need to take any action as your 2009 benefit elections will automatically carry over to 2010 **(with the exception of the flexible spending account election as noted below)**.

- **Please be aware that your 2009 flexible spending account elections will not automatically carry over to 2010**. If you are interested in establishing a 2010 flexible spending account, you **must enroll/re-enroll** through Benetrac **no later than 5:00 p.m. on Friday, November 20, 2009.**

How do I participate in Open Enrollment?

- Submit all changes via Benetrac, our online enrollment system. Your benefit elections will be effective January 1, 2010. You can access the system through SurfNet or at www.surfcity-hb.org/employee_benefits. Benetrac instructions are available online on SurfNet. **All elections must be received by Human Resources/Employee Benefits no later than 5:00 p.m. on Friday, November 20, 2009.**

- For any changes to CalPERS medical elections, you must submit them directly to Human Resources/ Employee Benefits on the CalPERS change form, which is available on SurfNet. **Note: Open enrollment for CalPERS is September 14, 2009 through October 9, 2009 ONLY.**

Reminder: Please review your personal information within Benetrac and make sure that your address, beneficiaries, etc. are up-to-date.

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: Benefits staff will be holding on-site enrollment assistance sessions on various dates, including the CalPERS Health Fair scheduled in the Police Department Classroom A on Thursday, October 1. Check SurfNet for the calendar and details.

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, 2010

What will be the same on January 1, 2010?

- Benefit Carriers for all plans will remain the same (with the exception of our Life/AD&D and Disability carrier).

- The maximum age for dependents (non-students) on the dental and vision plans will remain at age 25. Note: The maximum age for dependents on the medical plans is age 23.

What will change on January 1, 2010?

- Refer to the Open Enrollment Newsletter in your CalPERS Open Enrollment packet for additional information on the CalPERS health plans.

- Standard Insurance Company will replace Reliance Standard as our new Life/AD&D and Disability carrier. All benefits will remain the same as current, except for the employee guaranteed issue amount which will increase from $120,000 to $150,000. Guaranteed issue only applies to members during their initial eligibility period. All current elections, including voluntary life, will continue through Standard Insurance Company (no additional paperwork or proof of health status is required). Please see pages 10-11 for details regarding benefits. (Note: The City contributes towards a long-term disability plan provided by the Police Officers' Association for POA/PMA).

- Employee contributions will change.

- Rate sheets will be posted on SurfNet/Human Resources/Employee Benefits/2010 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 "Special Enrollment Rights" section below for special enrollment qualifications. To terminate coverage, you must contact Human Resources/Employee Benefits.

Dependent Eligibility

The definition of dependent includes your spouse, registered domestic partner, and unmarried children under 23 (medical) or 25 (dental/vision) years of age who are dependent upon you for more than one-half of his or her financial support. Unmarried children include stepchildren, registered domestic partner's children, and children placed under a "qualified medical child support order," adopted children or children placed for adoption. 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 below), they will not be eligible to enroll until the next Open Enrollment period.

Special Enrollment Rights

Other than during the annual Open Enrollment period, you may not change your coverage unless you qualify for a "special enrollment." In addition, if you are declining enrollment for you or your dependents (including your spouse) because of other group medical coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you qualify for a "special enrollment." The request for enrollment must be made within 30 days of your other coverage termination and include supporting documentation. The following are events that qualify for "special enrollment:"

- Marriage, legal separation, divorce, or death
- Birth, adoption, or placement for adoption of a child
- Retirement or termination of employment
- Spouse's/partner's termination of employment or new employment
- Change in employment from full-time to part-time or vice versa for you or your spouse/partner
- Change in medical coverage by spouse's/partner's employer
- Loss of medical coverage from spouse's/partner's employer

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 between the Blue Shield HMO, Blue Shield NetValue 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. **You have an option between the PERS Care, PERS Choice, PERS Select, 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 2010 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.

Medical Plan Features

HMO OPTIONS SCHEDULE OF BENEFITS		
PLAN BENEFITS	PERS BLUE SHIELD HMO & NET VALUE HMO*	PERS KAISER HMO
OFFICE VISITS	$15 Copay	$15 Copay
PRESCRIPTION DRUG **(must use a participating pharmacy)**	(not to exceed 30-day supply) $5 Generic $15 Brand $45 Non-Formulary	(not to exceed 30-day supply) $5 Generic $15 Brand
PRESCRIPTION DRUG - MAIL ORDER**	(not to exceed 90-day supply)** $10 Generic /$25 Brand $75 Non-Formulary	(up to 30-day supply) $5 Generic/$15 Brand (31-100 day supply) $10 Generic/$30 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
LIFETIME MAXIMUM	Unlimited	Unlimited
ROUTINE PHYSICAL EXAMS	No Charge	No Charge (for physical exam)
CHIROPRACTIC	Not Covered	Not Covered (discounts available up to 25% off)
VISION EXAM	No Charge	No Charge
HOSPITAL SERVICES **Inpatient** **Outpatient**	 No Charge $15/Visit	 No Charge $15/Visit
OUTPATIENT LAB & X-RAY	No Charge	No Charge
SUBSTANCE ABUSE PROGRAM **Inpatient** **Outpatient**	 See EOC	 No Charge (detox only) $15 Copay individual / $5 Group
MENTAL HEALTH **Inpatient** **Outpatient – (*Severe*)** **Outpatient – *Evaluation***	 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.blueshieldca.com.

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Medical Plan Features

Plan Benefits	PERS CHOICE & SELECT* LOW OPTION PPO		PERS CARE HIGH OPTION PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
OFFICE VISITS	$20 Copay	40%	$20 Copay	40%
PRESCRIPTION DRUG **Retail Pharmacy** **Retail Pharmacy – Maintenance Drugs after 2nd Fill**	(not to exceed 30-day supply) $5 Generic $15 Brand $45 Non-Formulary ($30 if waiver approved) (not to exceed 30-day supply) $10 Generic $25 Brand $75 Non-Formulary ($45 if waiver approved)		(not to exceed 34-day supply) $5 Generic $15 Brand $45 Non-Formulary ($30 if waiver approved) (not to exceed 34-day supply) $10 Generic $25 Brand $75 Non-Formulary ($45 if waiver approved)	
PRESCRIPTION DRUG - MAIL ORDER (90-Day Supply)	$10 Generic $25 Brand $75 Non-Formulary ($45 if waiver approved)		$10 Generic $25 Brand $75 Non-Formulary ($45 if waiver approved)	
EMERGENCY SERVICES	20% ($50 deductible waived if admitted as an inpatient or for observation as an outpatient)		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
PLAN LIFETIME MAXIMUM	$2,000,000 (per individual)		N/A	
DURABLE MEDICAL EQUIPMENT	20%	40%	10%	40%
	$6,000 annual max		Pre-certification required for equipment priced at $1,000 or more	
CHIROPRACTIC/ACUPUNCTURE	20%	40%	10%	40%
	(15 visits per year)		(20 visits per year)	
Inpatient HOSPITAL SERVICES	20%	40%	10%	40%
			($250 deductible)	
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	

*The PERS Select plan benefits mirror the PERS Choice plan; however, PERS Select offers Anthem Blue Cross' "high performance network", only available in certain counties.

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Medical Plan Features

Plan Benefits	PORAC ANTHEM BLUE CROSS PPO	
	PPO IN-NETWORK	NON-PPO OUT-OF-NETWORK
OFFICE VISITS	$20 Copay (deductible does not apply)	10% (varies)
PRESCRIPTION DRUG **(30-day supply)**	$10 Generic $25 Brand $45 Non-Formulary / Compound	$10 Generic $25 Brand $45 Non-Formulary (Compound Not Covered)
PRESCRIPTION DRUG - MAIL ORDER **(90-day supply)**	$20 Generic $40 Brand $75 Non-Formulary	N/A
EMERGENCY SERVICES	10%	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
PLAN LIFETIME MAXIMUM	N/A	
DURABLE MEDICAL EQUIPMENT	20%	20% (varies)
CHIROPRACTIC	20 Visits	$700 Maximum Benefit
	Maximum combined with Physical and Occupational Therapy	
ACUPUNCTURE	$20 (10% for all other services)	10% (varies)
HOSPITAL SERVICES	10%	10% (varies)
OUTPATIENT LAB & X-RAY	10%	10% (varies)
SUBSTANCE ABUSE PROGRAM **Inpatient** **Outpatient**	10%	10% (varies)
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	$2,000 max. benefit		Unlimited
DEDUCTIBLE Individual/Family	$25 per person / $75 per 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 (PPO only)	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

Plan Benefits	VISION SERVICE PLAN (VSP) VISION	
	In-Network	Out-Of-Network
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)*	$15 Copay *	$45 Allowance (copay applies)
STANDARD LENSES Single Vision Bifocal Trifocal	$15 Copay * $15 Copay * $15 Copay *	Up to $45 Allowance Up to $65 Allowance Up to $85 Allowance
FRAMES	Up to $120 Allowance	Up to $47 Allowance
LASER VISION CORRECTION (US LASER NETWORK)	Discounts at participating facilities	N/A
CONTACT LENSES: Elective Medically Necessary	Up to $120 Allowance Covered in full	Up to $105 Allowance Up to $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)

MSOA/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 MSOA employees) 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.

POA/PMA: The City contributes towards a long-term disability plan provided by the Police Officers' 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 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 first of the month following underwriting approval.

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 enrollment packet and summary sheet for more information. This information is available online on SurfNet.

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, over-the-counter medications 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 PLAN (EAP)

The EAP plan (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.

EMPLOYEE BENEFITS CONTACT INFORMATION

Human Resources – Employee Benefits

- Intranet: http://surfnet/Human_Resources/
- 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
- To verify your benefits, visit:

www.surfcity-hb.org/employee_benefits

Blue Shield (MEA, MEO, HBFA, NA)

- www.blueshieldca.com/csac
- HMO Medical and Rx (Group #EH1009)
  (800) 642-6155
- PPO Medical (Group #E10055)
  (800) 642-6155
- PPO Rx through Medco Pharmacy (Group # E10055000)
  (800) 711-0917
- Safety PPO Medical (Group #E10056)
  (800) 642-6155
- Safety PPO Rx through Medco Pharmacy
  (Group # E10056000) (800) 711-0917

Kaiser (MEA, MEO, HBFA, NA)

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

CalPERS Medical (POA, PMA, MSOA, FMA)

- www.calpers.ca.gov
  (888) 225-7377 or (888) CAL-PERS
- CalPERS Blue Shield HMO (Group #PH0001)
  (800) 334-5847
- CalPERS Blue Shield Net Value (Group #PH0010)
  (800) 334-5847
- CalPERS Kaiser HMO (Group #105705-00)
  (800) 464-4000
- CalPERS Blue Cross PORAC (Group #13079)
  (800) 288-6928
- CalPERS Blue Cross - PERS Choice (Group #CB050A)
  (877) 737-7776
- CalPERS Blue Cross - PERS Care (Group #KB050A)
  (877) 737-7776
- CalPERS Blue Cross - PERS Select (Group #SB050A)
  (877) 737-7776

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

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

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.

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.surfcity-hb.org/employee_benefits.

MEDICARE PART D

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 City of Huntington Beach Medical 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 (upon turning age 65,

under age 65 with certain disabilities, and individuals with permanent kidney failure) and each year from November 15th through December 31st. 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 November to join.

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'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).

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact Human Resources at 2000 Main Street, Huntington Beach, CA 92648 or call (714) 375-8456.

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.

THE NEWBORNS AND MOTHERS PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The health benefits of most plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas. Plan participants must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the WHCRA.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

The Group Health Plan you are enrolling in (may) impose a pre-existing condition limitation or exclusion on new enrollees for a period of 12 months from the start of your waiting period. For a newly hired employee, the start of your waiting period is typically the day you begin work for this employer. If your plan imposes a waiting period, that time will count toward satisfaction of any pre-existing limitation or exclusion. If you have a break in coverage less than 63 days, your previous coverage period can also be used to reduce this waiting period. A pre-existing condition is defined as a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the start date of your waiting period.

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 City of Huntington Beach's HIPAA Privacy Notice. You can request a copy of the Privacy Notice by contacting Human Resources.

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

On February 4th, 2009, President Obama signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). This law extends and expands the state children's health insurance program (CHIP).

New Disclosure Requirements

The law amends the Internal Revenue Code, ERISA and the PHSA to require group health plan administrators to disclose information about plan benefits to States upon request when a plan participant or beneficiary is covered under Medicaid or CHIP. This information is intended to allow States to determine eligibility, the cost-effectiveness of providing premium assistance for the purchase of coverage under the group health plan, and to provide supplemental benefits. The Department of Health and Human Services (HHS) and the Department of Labor (DOL) are to establish a working group and develop a model coverage coordination disclosure form for plan administrators to complete. States may not request the model coverage coordination disclosure form until the first plan year that begins after the date on which the form is first issued.

New Special Enrollment Requirements

The law also creates additional special enrollment rights. Group health plans will now be required to permit employees and dependents who are eligible but not enrolled for coverage to enroll upon termination of the employee or dependent's Medicaid or CHIP coverage or if the employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP. In both instances, the employee must request coverage under the plan within 60 days after the termination or determination of subsidy eligibility. These new special enrollment rights are effective April 1, 2009.

New Employer Notification Requirement

There are additional new notification requirements for employers that maintain group health plans in states that provide Medicaid or CHIP assistance in the form of premium assistance subsidies. These employers will be required to provide written notices to their employees, informing them of the potential opportunities for premium assistance in the states in which they reside to help pay for health coverage for employees or dependents. The new law directs HHS to develop national and state-specific model notices by February 4, 2010 to enable employers to comply with the notice requirement. Employers may provide these notices along with other plan materials (for example, eligibility notice, open enrollment materials, or when furnishing the SPD). The notice requirement is effective for plan years beginning after the date on which the model notices are first issued.

Premium Assistance

Under CHIPRA, the premium assistance available for employer-sponsored insurance can be paid directly to the employer, or the employer can opt-out of receiving payments directly resulting in the state providing premium assistance directly to employees. The amount of premium assistance available is the incremental premium cost difference between coverage for the employee only and coverage for the employee plus the eligible child/children.

Employee Benefits Brochure designed and developed by

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