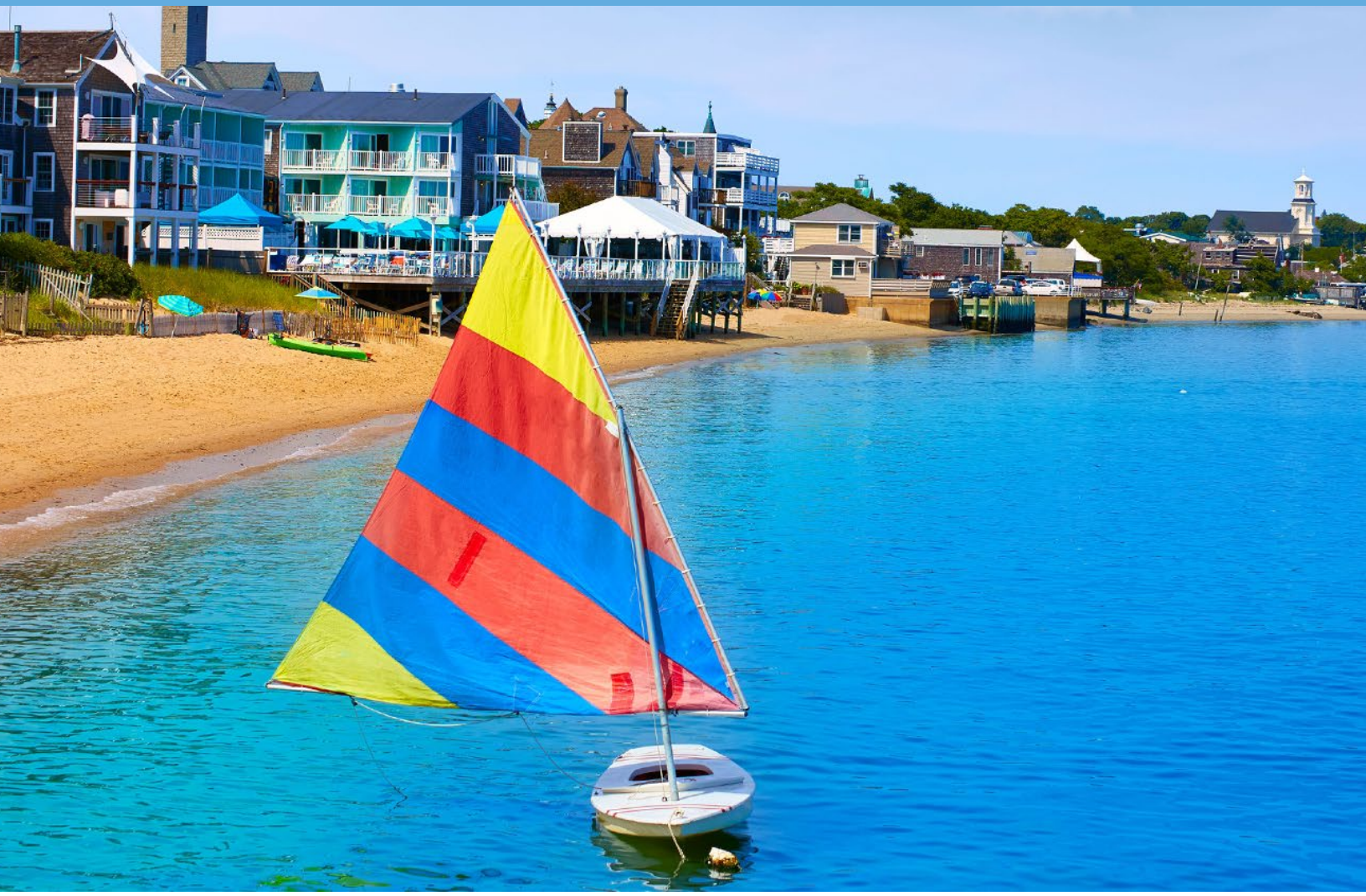
2020

COBRA Benefits Overview

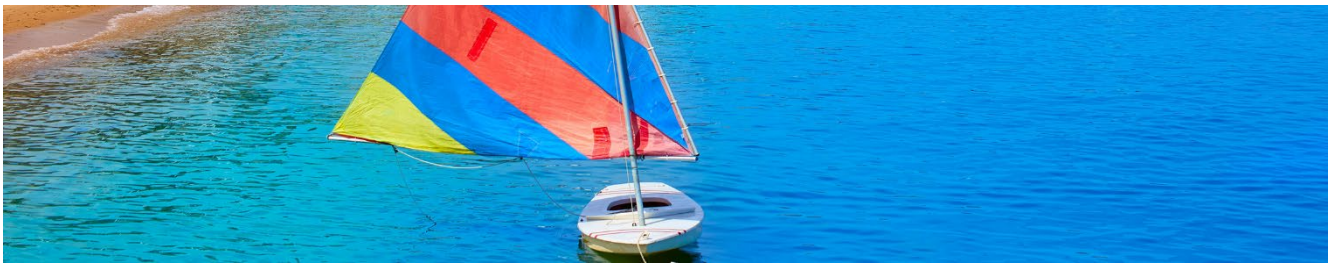


Council Members

TABLE OF CONTENTS

Medicare Part D Notice: If you (and/or your dependents) 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 the Annual Notices on page 17 - 16 for more details.

Make Life Even Better



This overview helps you to understand the benefits available to you and how to best use them. Please review this brochure carefully. If you have any questions regarding your benefits, a list of plan contacts is provided at the back of this brochure for your reference.

While we have made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefits booklets or summary plan descriptions. The plan benefits booklets provide details on how benefits are paid.

Benefits are effective:

January 1, 2020 - December 31, 2020

Making the Most of Your Benefits Program

Helping you and your family members stay healthy and making sure you use your benefits program to its best advantage is our goal in offering this program. Here are a few things to keep in mind.

STAY WELL!

Harder than it sounds, of course, but many health problems are avoidable. Take action—from eating well, to getting enough exercise and sleep. Taking care of yourself takes care of a lot of potential problems.

ASK QUESTIONS AND STAY INFORMED

Know and understand your options before you decide on a course of treatment. Informed patients get better care. Ask for a second opinion if you're at all concerned.

GET A PRIMARY CARE PROVIDER

Having a relationship with a PCP gives you a trusted person who knows your unique situation when you're having a health issue. Visit your PCP or clinic for non-emergency healthcare.

GOING TO THE DOCTOR?

To get the most out of your doctor visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of what you want to talk about with your doctor

If you need a medication, you could save money by asking your doctor if there are generics or generic alternatives for your specific medication.

AN APPLE A DAY

Eating moderately and well really does help keep the doctor away. Stay away from fat-heavy, processed foods and instead focus on whole grains, vegetables, and lean meats to be the healthiest you can be.

EMERGENCY ROOM VS. URGENT CARE

The emergency room should not be your first choice unless there's a true emergency—a serious or life threatening condition that requires immediate attention or treatment that is only available at a hospital.

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

BE MED WISE!

Always follow your doctor's and pharmacist's instructions when taking medications. You can worsen your condition(s) by not taking your medication or by skipping doses. If your medication is making you feel worse, contact your doctor.

GOING ABROAD? (BLUE SHIELD MEMBERS ONLY)

When you travel overseas, you can rely on the BlueCard® Program. This program offers access to an international network of participating doctors and hospitals for a broad range of medical care services. For non-emergency medical care outside the U.S, call the BlueCard® Program at 800-810-BLUE. The center is available 24/7, and is staffed with multilingual representatives who can help coordinate your medical care.

Medical Overview

The City of Huntington Beach's goal is to provide you with affordable, quality healthcare 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.

PREFERRED PROVIDER ORGANIZATION (PPO)

Preferred Provider Organization (PPO) plans are designed to provide you with choice and flexibility. They allow you to see any provider of your choice (in-network and out-of-network providers); however, by choosing to access care with a participating (in-network) provider, you will significantly reduce your out-of-pocket expenses. Participating providers are doctors, hospitals, pharmacies, and labs, etc., that participate in your carrier's network and have agreed to provider at pre-negotiated reduced rates.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

Like the PPO, the HDHP (High Deductible Health Plan) provides in-network and out-of-network coverage. This plan also 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 copays listed will apply. The Preventive Care benefits are covered at no change regardless of deductible being met.

The HSA (Health Savings Account) is available to you if you are enrolled in the HDHP plan. For more information on the HSA, please see page 11.

CARRUM HEALTH SERVICES (PPO & HDHP MEMBERS ONLY)

Learning you need surgery can be frightening. Simple questions such as "how much will I have to pay?" and "which surgeon should I see?" are difficult to answer. Carrum Health is designed to deliver a superior end-to-end experience for you and your family.

Carrum Health is a special surgery benefit that provides exclusive access to "Centers of Excellence." These facilities and doctors provide an improved patient experience, high quality of care, and zero or minimal out-of-pocket costs.

HEALTH MAINTENANCE ORGANIZATION (HMO)

The primary objective of a Health Maintenance Organization (HMO) plan is to offer you and your dependents quality coverage at a lower cost. If you select the Blue Shield HMO, you must choose a primary care physician (PCP) and medical group, who will then coordinate your care through the carrier's network of physicians and hospitals, resulting in cost savings for you. You will access most of your healthcare services through your PCP.

Kaiser's network is a unique model as the insurance company employs hospitals, doctors, and nurses which members would receive all treatment from, except in an emergency. This "closed" system offers high quality care and benefits at a low cost relative to other insurance companies. Kaiser does not require members to select a PCP.

TELADOC (BLUE SHIELD MEMBERS ONLY)

Teladoc's U.S. board-certified doctors are available 24/7/365 to resolve many of your medical issues through phone or video consults. Teladoc does not replace your primary care physician. It is a convenient and affordable option for quality care, such as:

- When you need care now,
- If you're considering the ER or urgent care center for a nonemergency issue,
- On vacation, on a business trip, or away from home, or,
- For short-term prescription refills

Set up your account today. Go to teladoc.com and click "Set up Account" and provide the required information. You can also call Teladoc at (800) 835-2362. **Teladoc service is available to Blue Shield members only.**

Medical

Below you will see a summary of benefits for the Kaiser HMO and the Blue Shield HMO plans.

	Kaiser HMO	Blue Shield HMO
	In-Network	In-Network
Annual Deductible	None	None
Annual Out-of-Pocket Max	$1,500 / individual $3,000 / family	$1,000 / individual and an individual in a family $2,000 / family
Lifetime Max	Unlimited	Unlimited
Office Visit		
Primary Provider	$20 copay	$15 copay
Specialist	$20 copay	$15 copay ($30 copay if self-referred)
Preventive Services	No Charge	No Charge
Chiropractic Care	$10 (max 30 visits per calendar year)	Not Covered
Lab and X-ray	No Charge	No Charge
Inpatient Hospitalization	$100 / admit	$100 admission copay
Outpatient Surgery	$20 procedure copay	No Charge
Urgent Care	$20 copay	$15 copay
Emergency Room (copay waived if admitted)	$200 copay / visit	$200 copay

Medical, continued

Here is an overview of our PPO and HDHP medical plans, provided by Blue Shield.

	Blue Shield - PPO		Blue Shield – HDHP*	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Annual Deductible	$750 / individual $1,500 / family	$1,000 / individual $2,000 / family	$2,000 / individual $6,000 / family	$4,000 / individual $12,000 / family combined with in network
Annual Out-of-Pocket Max	$3,750 / individual $7,500 / family	$10,000 / individual $20,000 / family	$6,350 / individual and an individual in a family $12,700 / family	$12,700 / individual $38,100 / family combined with in-network
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited
Office Visit				
Primary Provider	$30 copay	40% after deductible	30% after deductible	50% after deductible
Specialist	$50 copay	40% after deductible	30% after deductible	50% after deductible
Preventive Services	No Charge	40%	No Charge	Not covered
Chiropractic Care	20% after deductible (up to 15 visits per year; acupuncture combined)	40% after deductible (in-network limitations apply)	30% after deductible (up to 26 visits per year; acupuncture combined)	50% after deductible (in-network limitations apply)
Lab and X-ray (office location only)	$30 copay after deductible	40% after deductible	30% after deductible	50% after deductible
Inpatient Hospitalization	20% after deductible	40% after deductible (up to $600 per day)	30% after deductible	50% after deductible (up to $600 per day)
Outpatient Surgery	20% after deductible	40% after deductible (up to $350 per day)	30% after deductible	50% after deductible (up to $350 per day)
Emergency Room	20% after $200 copay	20% after $200 copay	30% after deductible	30% after deductible

***For the HDHP Plan please note the following:**

Calendar Year Medical Deductible: For individual on family coverage, one or more in the family can satisfy the family deductible.

Calendar Year Out-of-Pocket Maximum: For individual on family coverage plan, the individual can receive 100% benefits for covered services once the individual out-of-pocket maximum is met. Out-of-pocket maximum accumulates separately for Participating and Non Participating providers.

Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure.

Council Members who are enrolled in the Blue Shield HMO and PPO plans will have prescription drug coverage through Express Scripts. Council Members who are enrolled in the Blue Shield HDHP plan will have prescription drug coverage through Blue Shield. 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 and PPO members can use Express Scripts as their mail service pharmacy by calling (800) 711-0917. Blue Shield HDHP members can use PrimeMail as their mail service by calling (866) 346-7200. Please refer to the schedule of benefits in this brochure for more information.

	Kaiser HMO	Blue Shield HMO	Blue Shield PPO		Blue Shield HDHP	
	In-Network	In-Network	In-Network	Out-Of-Network	In-Network	Out-of-Network
Prescription Drug Deductible (Brand only)	Not Applicable	$100 Individual / $300 Family	$100 Individual / $300 Family	$100 Individual / $300 Family	Subject to the medical deductible	Subject to the medical deductible
Annual Out-of-Pocket Limit	Not Applicable	$5,600 Individual / $11,200 Family	$2,850 Individual / $5,700 Family	Out-of-Network claims do not apply to the OOPM	**Prescription drugs accumulate towards the medical annual out-of-pocket limit**	
Pharmacy						
Generic	$15 copay	$10 copay	$10 copay	$10 copay	30% after deductible	30% after deductible
Preferred Brand	$30 copay	$30 copay	$20 copay	$20 copay	30% after deductible	30% after deductible
Non-preferred Brand	Not covered	$50 copay	$50 copay	$50 copay	30% after deductible	30% after deductible
Supply Limit	30 days	30 days	30 days	30 days	30 days	30 days
Mail Order						
Generic	$30 copay	$20 copay	$20 copay	Not covered	30% after deductible	Not Covered
Preferred Brand	$60 copay	$60 copay	$40 copay	Not covered	30% after deductible	Not Covered
Non-preferred Brand	Not covered	$100 copay	$100 copay	Not covered	30% after deductible	Not Covered
Supply Limit	100 days	90 days	90 days	N/A	90 days	N/A

Pharmacy benefits for Blue Shield HMO and PPO is administered by Express Scripts.

Visit www.Express-Scripts.com for more information.

Dental

Regular visits to your dentist can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

The City of Huntington Beach gives you a choice between two dental plans through Delta Dental of California.

	Delta Dental PPO		Delta Dental HMO
	In-Network	Out-Of-Network	In-Network
Calendar Year Deductible (combined with in-network)	$25 $75	$25 $75	$0 $0
Annual Plan Maximum	$2,000 per person	$2,000 per person (combined with in-network)	Unlimited
Waiting Period	None	None	
Diagnostic and Preventive	15%; deductible waived	15% after deductible	Plan pays 100% (see contract for fee schedule)
Basic Services			
Fillings	15% after deductible	15% after deductible	Plan pays 100% (see contract for fee schedule)
Root Canals	15% after deductible	15% after deductible	Plan pays 100% (see contract for fee schedule)
Periodontics	15% after deductible	15% after deductible	Plan pays 100% (see contract for fee schedule)
Major Services	Prosthodontics: 40% after deductible; All other: 15% after deductible	Prosthodontics: 40% after deductible; All other: 15% after deductible	Plan pays 100% (see contract for fee schedule)
Orthodontic Services			
Orthodontia	40% after deductible	40% after deductible	$500 + start up for normal 24 month treatment (see contract for fee schedule)
Lifetime Maximum	$3,000	$3,000 (combined with in-network)	Unlimited
Dependent Children	Covered	Covered	Covered

Members will be responsible for the difference in non-Delta charges more than Delta's allowable fees.

For Delta Dental HMO members, please refer to the full benefit description for a complete listing of basic covered services, costs for treatment upgrades, and any limitations and exclusions.

Vision

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions.

Your vision coverage is offered by Vision Service Plan (VSP), who has the largest network of private vision providers in the nation.

Log on to VSP's website at vsp.com or call (800) 877-7195 for more information.

	Vision Service Plan Vision	
	In-Network	Out-Of-Network
Examination		
Benefit	$15 copay	Up to $50 allowance
Frequency	12 months	12 months
Materials	100% after $15 copay (combined with exam copay)	See schedule below
Eyeglass Lenses		
Single Vision Lens	Combined with Exam	Up to $50
Bifocal Lens	Combined with Exam	Up to $75
Trifocal Lens	Combined with Exam	Up to $100
Frequency	12 months	12 months
Frames		
Benefit	Up to $120	Up to $70 allowance
Frequency	12 months	12 months
Contacts (Elective)		
Benefit	Up to $120 allowance (instead of eyeglasses)	Up to $105 allowance (instead of eyeglasses)
Frequency	12 months	12 months

Health Savings Account (HSA)

Do you want to save money on taxes? A Health Savings Account is a tax-advantaged, portable (you own it!) savings account that is offered if you enroll in our compatible High Deductible Health Plan. Our HSA accounts are administered by Optum.

You contribute pre-tax money to your account to save for out-of-pocket healthcare expenses. Any money that you don't spend rolls over year after year and can be used in the future, even after you retire. The IRS has not changed its definition of a dependent for health savings accounts. This means that a Council Member whose 24-year or older child is covered on their HSA-qualified health plan is not eligible to use HSA funds to pay that child's medical bills, unless they are an IRS qualified dependent. **Please note:** Some states do not recognize pre-tax HSA contributions on a state level.

ACCOUNT CONTRIBUTIONS

	You Contribute
Annual Single Contribution Maximum	Up to $3,550
Annual Family Contribution Maximum	Up to $7,100
Annual Catch-up Contribution Maximum	$1,000 (for HSA participants that are 55 years and older)

Contribution limits: The IRS has set limits on the total amount you can contribute to a Health Savings Account each calendar year. In 2020, the limit is $3,550 for an individual and $7,100 for a family. If you're over 55, the IRS allows you to contribute an additional $1,000—this is called a "catch-up contribution."

USING YOUR MONEY

You can use the money in your account to pay for qualified medical expenses that are not paid for by your high deductible health plan (HDHP). For a full list of those expenses, go to **irs.gov**. In general, your HSA can be used for these expenses without penalty:

- Medically necessary expenses that are not covered by your health plan including deductibles and coinsurance
- Dental care services
- Vision care services
- Prescription drugs
- Over-the-counter (OTC) medications prescribed by your doctor
- Certain medical equipment

When possible, use your HSA debit card to pay for expenses. Make sure that you keep records of your receipts including receipts for any over-the-counter (OTC) supplies and medications prescribed by your doctor. You will need them to prove that you spent the money on qualified expenses if you are audited by the IRS.

ELIGIBILITY

You are eligible to open or contribute to an HSA account if you are:

- Covered by a high deductible health plan
- Not enrolled in a regular healthcare flexible spending account (you and/or your spouse)
- Not covered under Medicare or Medicaid
- Not a veteran
- Not claimed as a dependent on someone else's tax return

NON-QUALIFIED EXPENSES

If you use HSA funds for non-qualified expenses before age 65, you will owe a 20% penalty tax PLUS income tax on the withdrawal. After age 65, if you use HSA funds for non-qualified expenses, you will owe income tax only.

For Assistance

If you need to reach our plan providers, here are their contact information:

Plan Type	Provider	Phone Number	Website	Policy/Group #
Medical	Kaiser	(800) 464-4000	www.kp.org	227450
	Blue Shield	(855) 256-9404	www.blueshieldca.com	W0052144
Prescription	Express Scripts	(877) 554-3091	www.express-scripts.com	Rx BIN: 610014 Rx Group: RX4EIAH
TelaHealth	Teladoc	(800) 835-2362	www.teladoc.com	N/A
NurseHelp 24/7SM	Blue Shield	(877) 304-0504	www.blueshieldca.com	N/A
Surgery Concierge	Carrum	(888) 855-7806	www.carrum.me/EIAHEALTH	N/A
Dental	Delta Dental PPO	(800) 765-6003	www.deltadentalins.com	04729
	Delta Dental HMO	(800) 422-4234	www.deltadentalins.com	71575
Vision	VSP	(800) 877-7195	www.vsp.com	00105162
HSA Bank	Optum	(866) 234-8913	www.optumbank.com	N/A
Benefits	Human Resources	(714) 375-8456	SurfNet	N/A

Key Terms

MEDICAL/GENERAL TERMS

Allowable Charge - The most that an in-network provider can charge you for an office visit or service.

Balance Billing - Non-network providers are allowed to charge you more than the plan's allowable charge. This is called Balance Billing.

Coinsurance - The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible for paying the remaining 30% of the cost.

Copay - The fee you pay to a provider at the time of service.

Deductible - The amount you have to pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

Explanation of Benefits (EOB) - The statement you receive from the insurance carrier that explains how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay a bill from your provider until you have received and reviewed your EOB (except for copays).

Family Deductible - The maximum dollar amount any one family will pay out in individual deductibles in a year.

Individual Deductible - The dollar amount a member must pay each year before the plan will pay benefits for covered services.

In-Network - Services received from providers (doctors, hospitals, etc.) who are a part of your health plan's network. In-network services generally cost you less than out-of-network services.

Out-of-Network - Services received from providers (doctors, hospitals, etc.) who are not a part of your health plan's network. Out-of-network services generally cost you more than in-network services. With some plans, such as HMOs and EPOs, out-of-network services are not covered.

Out-of-Pocket - Healthcare costs you pay using your own money, whether from your bank account, credit card, Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Out-of-Pocket Maximum – The most you would pay out-of-pocket for covered services in a year. Once you reach your out-of-pocket maximum, the plan covers 100% of eligible expenses.

Preventive Care – A routine exam, usually yearly, that may include a physical exam, immunizations and tests for certain health conditions.

PRESCRIPTION DRUG TERMS

Brand Name Drug - A drug sold under its trademarked name. A generic version of the drug may be available.

Generic Drug – A drug that has the same active ingredients as a brand name drug, but is sold under a different name. Generics only become available after the patent expires on a brand name drug. For example, Tylenol is a brand name pain reliever commonly sold under its generic name, Acetaminophen.

Dispense as Written (DAW) - A prescription that does not allow for substitution of an equivalent generic or similar brand drug.

Maintenance Medications - Medications taken on a regular basis for an ongoing condition such as high cholesterol, high blood pressure, asthma, etc. Oral contraceptives are also considered a maintenance medication.

Non-Preferred Brand Drug - A brand name drug for which alternatives are available from either the plan's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.

Preferred Brand Drug - A brand name drug that the plan has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of clinical effectiveness and cost.

Specialty Pharmacy - Provides special drugs for complex conditions such as multiple sclerosis, cancer and HIV/AIDS.

Step Therapy - The practice of starting to treat a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

DENTAL TERMS

Basic Services - Generally include coverage for fillings and oral surgery.

Diagnostic and Preventive Services - Generally include routine cleanings, oral exams, x-rays, sealants and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Endodontics - Commonly known as root canal therapy.

Implants - An artificial tooth root that is surgically placed into your jaw to hold a replacement tooth or bridge. Many dental plans do not cover implants.

Major Services - Generally include restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Orthodontia - Some dental plans offer Orthodontia services for children (and sometimes adults too) to treat alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.

Periodontics - Diagnosis and treatment of gum disease.

Pre-Treatment Estimate - An estimate of how much the plan will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

Required Federal Notices

Medicare Part D Notice

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. The City of Huntington Beach has determined that the prescription drug coverage offered by all of our plan options 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 will not 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 all of our plan options 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.

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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. 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 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 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 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, 2020
Name of Entity/Sender:	City of Huntington Beach
Contact-Position/Office:	Human Resources
Address:	2000 Main Street, Huntington Beach, CA 92648
Phone Number:	(714) 375-8456

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Required Federal Notices, Cont.

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 will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at member services.

Newborns' and Mothers' Health 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 section. 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for City of Huntington Beach describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Human Resources.

Required Federal Notices, Cont.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in City of Huntington Beach's 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 City of Huntington Beach's 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 City of Huntington Beach's health 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.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Notice of Choice of Providers

HMO plans generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carrier directly.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the plans offered or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your carrier directly.

Notes

Notes

Notes

Rev. 9/11/2019