

2020

Employee Benefits Overview



MEA

(For Dental and Vision Plans Only)



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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 14 - 17 for more details.

Make Life Even Better.



Helping you and your families achieve and maintain good health—physical, emotional and financial—is the reason the City of Huntington Beach offers you a choice of benefit programs. 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.

Here is what's happening for 2020:

- Benefit carriers for medical, dental, vision, basic life/AD&D, supplemental life/AD&D, long term disability, EAP and FSA will remain the same.
- The City still pays a portion of the cost toward coverage for you and your covered family members to offset this year's increases. This year's rate sheets can be viewed on [SurfNet/Human Resources/Employee Benefits/2020 Health Premiums and Contributions](#).

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.

The Human Resources Department has taken many steps to allow easy access to information about your health and benefit plans. Please visit the City's intranet site, SurfNet, to view the Employee Benefits information. 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!

Benefits are effective:

January 1, 2020 - December 31, 2020

Who Can You Cover?



WHO IS ELIGIBLE?

Permanent employees working 20 or more hours per week are eligible for the benefits outlined in this overview.

You can enroll the following eligible family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse).
- Your registered same or opposite sex domestic partner is eligible for coverage. Any premiums for your domestic partner paid for by the City of Huntington Beach are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- Your children:
 - o Under the age of 26 are eligible to enroll in coverage. Children include birth children, stepchildren, adopted children, and children for whom you are a legal guardian. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
 - o Over age 26 may remain on the plan ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
 - o Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

WHO IS NOT ELIGIBLE?

Family members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.

- Employees who work less than 20 hours per week.

WHEN CAN I ENROLL?

Coverage for new hires begins on the 1st of Month following your date of hire. New employees must make an election within 31 days of becoming eligible.

Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event. (Teamsters Medical Open Enrollment is April/May.)

Make sure to notify Human Resources right away if you have a qualifying life event and need to make a change (add or drop) to your coverage election.

These changes include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage
- Divorce

You must submit the appropriate forms to add or drop a dependent from your plan. Forms can be found on SurfNet.

To add dependents, you have 30 days from the Qualifying Event to submit an “Add Dependent” form to Human Resources.

You are required to submit a “Delete Dependent” form to Human Resources within **30 days** of a dependent becoming ineligible such as divorce, or a covered dependent no longer eligible due to age, etc. **Failure to do so can jeopardize your COBRA rights.**

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.

Medical

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 the Teamsters Miscellaneous Security Trust Fund.

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 Anthem Blue Cross 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 does not require members to select a 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.

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 provide at pre-negotiated reduced rates.

MEDICAL OPT-OUT BENEFIT

Employees who are covered by another group-sponsored 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 2020 rate sheets.

Note: This benefit is included as a taxable income. Proof of outside coverage is required and recertification must be completed and on file annually in the Human Resource Office.

For information on MEA medical insurance provisions and coverage under the Teamsters Miscellaneous Security Trust Fund, Local 911, contact Northwest Administrators at (877) 214-8928.

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	N/A
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 allowance	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

Flexible Spending Account (FSA)



A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. The catch is that you have to use the money in your account by the end of the plan year and submit for reimbursement prior to the end of the run-out period. Otherwise, that money is lost (referred to as the “use it or lose it” rule) so plan carefully. **You must re-enroll in this program each year.** EBS administers this plan. If you are no longer employed with the City of Huntington Beach, your FSA will terminate on the same date as your employment termination.

IMPORTANT CONSIDERATIONS

- Expenses must be incurred between 01/01/20 through 12/31/20 (Grace period to 3/15/21) and submitted for reimbursement no later than 4/30/21,
- Elections cannot be changed during the plan year, unless you have a qualified change in family status (and the election change must be consistent with the event).
- Unused amounts will be lost at the end of the grace period, so it is very important that you plan carefully before making your election.
- FSA funds can be used for you, your spouse, and your tax dependents only.
- You can obtain reimbursement for eligible expenses incurred by your spouse or tax dependent children, even if they are not covered under the City's health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).
- Keep your receipts. In most cases, you will need to provide proof that your expenses were considered eligible for IRS purposes.

entire annual election from the first day of the plan year and you can set aside a minimum of \$100 up to \$2,700 this year.

Please note: If you open a Health Savings Account (HSA) you will not be eligible to enroll in the Healthcare FSA. If you still have funds in the Healthcare FSA, you must exhaust all the funds in the FSA before you can open an HSA.

DEPENDENT CARE FSA ACCOUNT

This plan allows you to pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. Eligible expenses may include daycare centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are considered your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can set aside up to \$5,000 per household for eligible dependent care expenses for the year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to \$2,500 each year.

HEALTHCARE FSA ACCOUNT

This plan allows you to pay for eligible out-of-pocket healthcare expenses with pre-tax dollars. Eligible expenses include medical, dental, or vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. You may access your

Life Insurance



If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security.

LIFE AND AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by the City. Coverage is provided by CIGNA Group.

Basic Life Amount	\$50,000
Basic AD&D Amount	\$50,000

VOLUNTARY LIFE

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by CIGNA Group.

Employee Voluntary Life Amount	Increments of \$10,000 up to \$500,000
Spouse Voluntary Life Amount	Increments of \$10,000 up to \$500,000 not to exceed 100% of employee Basic & Voluntary Life amounts combined
Child(ren) Voluntary Life Amount	\$2,500, \$5,000, \$7,500 or \$10,000.

VOLUNTARY AD&D

Voluntary AD&D Insurance allows you to purchase additional accidental death and dismemberment insurance to protect your family's financial security in case you suffer from loss of a limb, speech, sight or hearing or if you die in an accident. Coverage is provided by CIGNA Group.

Employee Voluntary AD&D Amount	\$25,000, \$50,000 or \$100,000
Family Voluntary AD&D Amount	Coverage available for spouses and dependent children, as a percentage of the employee's principal amount

Beneficiary Reminder: Make sure that you have named a beneficiary for your life insurance benefit. It is important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

Evidence of Insurability: Depending on the amount of coverage you select, you may need to submit an Evidence of Insurability form, which involves providing the insurance company with additional information about your health.

Other Programs



LONG-TERM DISABILITY INSURANCE

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind. Long-Term Disability coverage pays you a certain percentage of your income if you cannot work because an injury or illness prevents you from performing any of your job functions over a long time. It is important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security. **Long-term disability may only be used to cover non-work related injuries.**

Coverage is provided by CIGNA Group.

Monthly Benefit Amount	Plan pays 67% of covered monthly earnings
Maximum Monthly Benefit	\$12,500
Benefits Begin After:	
Accident	30 days of disability
Sickness	30 days of disability
Maximum Payment Period*	Social Security normal retirement age

*The age at which the disability begins may affect the duration of the benefits.

EMPLOYEE ASSISTANCE PROGRAM

There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through MHN, Inc. can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources. Best of all, it's free.

Help is available 24/7, 365 days a year by telephone at 800-242-6220. Other resources are available online at www.mhn.com. When you log in, enter 'huntingtonbch' as your access code.

In-person counseling may also be available, depending on the type of help you need. The program allows you and your family/household members up to 5 face-to-face clinical consultations per incident.

For Assistance

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

Plan Type	Provider	Phone Number	Website	Policy/Group #
Teamster Medical	Northwest Administrators	(877) 214-8928	www.nwadmin.com	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
FSA	WorkTerra	(888) 327-2770	www.workterra.com	N/A
Life and Disability	CIGNA	(800) 362-4462	www.mycigna.com	965003
EAP	MHN, Inc.	(800) 242-6220	www.mhn.com	N/A
Retirement	CalPERS	(888) 225-7377 (888) CAL-PERS	www.calpers.ca.gov	4840650877
	PARS Retirement	(800) 540-6369	www.parsinfo.org	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.
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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

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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

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