"KNOW YOUR BENEFITS"
FREQUENTLY ASKED QUESTIONS

Health Insurance (including dental and vision)

1. **Q: I only received two ID cards from the insurance company. I have three children. How do I get a card for every family member?**
   A: You have several options—
   - ✓ Call the Customer Service number and request additional cards
   - ✓ Go to their website and print out additional cards. NOTE: The City's dental and vision plans do not issue ID cards. However, to print an ID card go to: Dental – www.DeltaDentalIns.com Vision – www.VSP.com
   - ✓ Make copies
   - ✓ For MEA employees, contact NW Administrators at (877) 214-8928

2. **Q: I've lost my ID card (or never received one). What do I do?**
   A: See response to #1.

3. **Q: I want to change my doctor/dentist. Do I have to wait until Open Enrollment?**
   A: No. You may change your primary care physician/dentist as necessary. The change will be effective the first of the month after you have submitted the request to the carrier. However, to confirm the change has been made, you should contact Customer Service before scheduling an appointment with the new physician/dentist.

4. **Q: I just moved. What do I need to do?**
   A: You need to complete a Name/Address Change form (available at http://surfnet.cohb.net/forms/templates/Name%20-%20Address%20Change%20Form.doc) including the four-digits after your zip code and submit it to Human Resources as soon as possible. Human Resources will make the change in the City's databases for payroll, benefits, PERS health and retirement only. If you are enrolled in a deferred compensation program, you need to contact them directly and notify them of the change. Also, you should ensure your personal physicians accurately reflect your address on billing statements. Also, for MEA employees, NW Administrators has an Address Change Form – Submit it to Human Resources.

5. **Q: I need to see a doctor after regular office hours. What should I do?**
   A: Contact your primary physician and get authorization for treatment at a recommended urgent care facility by you or go to the Emergency Room for a life-threatening condition.

6. **Q: I disagree with my medical bill. I am charged for an amount that I do not think I owe. What can I do?**
   A:
   - Refer to the Evidence of Coverage for an explanation of benefits to see if a pre-authorization was required.
   - Check with your doctor's office to ensure that the proper codes, correct social security numbers, date of birth and address were used in billing.
   - You may also complete a grievance form if the matter is still not corrected to your satisfaction and file it with the insurance company to handle.

7. **Q: I just got married. How do I add my spouse to insurance?**
   A: Within **30 days**, you must notify Human Resources by completing an "Add Dependent" form which is available on the Human Resources Display Wall, through SurfNet/Human Resources/Employee Benefits or at www.surfcity-hb.org/employee_benefits where it is listed under "Forms" and attach a copy of the marriage certificate. For MEA employees, a carrier enrollment and Tier Participation form will also need to be completed.

8. **Q: My baby was born three months ago. How do I add him to my health insurance?**
   A: With the exception of the PERS Health Plans, you will need to wait until Open Enrollment as the child should have been added within 30 days of his/her birth with supporting documentation—i.e. birth certificate and social security number are required. (NOTE: The same procedure applies in the case of adoptions.)

9. **Q: My mother has come to live with us since my father died. Can I add her to my insurance?**
   A: No. Although you may be providing more than 50% financial support, a parent (nor a brother or sister) is not considered a dependent for insurance coverage.

10. **Q: At what age are my children no longer eligible on my insurance?**
    A: At the end of the month in which they reach 26 years of age. Overage dependents will be dropped, and the City may be obligated to offer them COBRA continuation coverage. **NOTE**: However, if they are eligible for health insurance from their own employer, they may not be enrolled in CalPERS or the Teamsters medical insurance plans.

11. **Q: My son is going to an out-of-state college. Can I still cover him for health insurance?**
    A: It depends on the area as there may not be participating Host HMO plans in every location. For the City's Blue Shield/CSAC, call 1-800-622-9402 or the City Kaiser plan, call 1-800-464-4000 30 days before your son goes away to school to apply and determine availability and difference in co-pays and out-of-pocket costs. For Teamsters' Kaiser or Blue Cross plans contact the customer service number for each provider or Northwest Administrators at (877) 214-8928.

    If you are in the City's Blue Shield PPO/CSAC or in the Teamsters' 75/25 Reimbursement Plan, you should check the insurance carrier's website to determine in-network providers to ensure your out-of-pocket expenses are kept to a minimum.

12. **Q: I just got divorced. What do I need to do to drop my spouse from insurance?**
    A: Within **30 days**, you must notify Human Resources by completing a "Delete Dependent" form which is available on the Human Resources Display Wall, through SurfNet/Human Resources/Employee Benefits or at www.surfcity-hb.org/employee_benefits where it is listed under "Forms" and attach a copy of the first page of your finalized divorce decree (Dissolution of Marriage). COBRA law mandates that the City offer up to 36 months' of group health to the ex-spouse at his/her expense. For MEA employees, you will also need to complete a Tier Participation form and carrier enrollment form.

13. **Q: I noticed on my Election Summary during Open Enrollment that my ex-spouse is still on my insurance. What should I do?**
    A: You should immediately provide Human Resources with a "Delete Dependent" form (available at http://surfnet/forms/templates/Delete%20Dependents%20Form%20rev%202011.pdf) with your Dissolution of Marriage attached. If it has been more than 30 days, you could be billed to reimburse the City for overpayment of premiums. The City will work with your to develop a mutually-acceptable repayment plan.

14. **Q: I did not drop my ex-spouse from my health insurance because in my divorce decree (Dissolution of Marriage), the courts stipulated that I must pay for insurance for my ex-spouse. Can I just keep her on as a dependent?**
    A: **NO.** Because of the divorce, the ex-spouse no longer enjoys "dependent status" from an insurance perspective. This means you must provide her with coverage in which she is listed as the primary insured individual, and you will need to pay 102% of the City's group rate for single coverage for COBRA. Otherwise, you may consider finding her separate coverage (outside of the City's group health plans).

    See Response #13 above and complete a "Delete Dependent" form that is available at http://surfnet/forms/templates/Delete%20Dependents%20Form%20rev%202011.pdf.

15. **Q: I have been with my girlfriend for many years and we feel we are "common law" husband and wife. However, we have never formally gotten married. I would like to add her to my insurance. What do I need to do?**
    A: Nothing. Legally you are unable to add an individual of the opposite sex as your spouse unless you are officially married or one of you is at least 62 years of age and registered with the State as Domestic Partners.

16. **Q: I would like to get insurance for my same sex partner. What do I need to do?**
    A: You will need to both register with the Secretary of State as Domestic Partners. Visit http://www.sos.ca.gov/dpregistry/forms.htm to obtain the form.

17. **Q: I got a bill for $1,000 from my health insurance carrier for medical services that I thought were covered under our plan. What should I do?**
    A: The first thing you need to determine is whether the services were provided by an in-network or out-of-network facility. Then you need to check the insurance plan document (Evidence of Coverage) or Plan Summary to see how much, if any, is paid by your insurance. To avoid future out-of-pocket expenses, you should check first to see if the services are being provided by an in- or out-of-network facility. If you believe the charge is excessive, you can file a grievance with your insurance company.

18. **Q: I got hit with a bill for going to the Emergency Room. I have the City's PPO Plan, and I thought the $200 was waived if I was admitted. How come I have to pay anything?**

A: The $200 is waived if you are admitted to the hospital for treatment (that is, not for observational purposes only or "visit"); however, you are responsible for 20% of the charges associated with any treatment in the ER. Also, if you then stay in the hospital for this event, you are responsible for either 20% or 40% of the charges, **depending upon whether or not the hospital is an in- or out-of-network provider**. For questions regarding the Teamsters' 75/25 Reimbursement Plan coverage, call Northwest Administrators at (626) 463-6068 or 6069.

19. **Q: What is the difference, if any, between deductibles and the maximum out-of-pocket expenses for PPOs?**

A: Deductibles are the payments for procedures you receive for professional services (such as outpatient, hospital, or emergency room services), but do not include co-pays for office visits and prescriptions. Deductibles are calculated first and do **not** apply toward the calendar year maximum.

Maximum out-of-pocket expenses are typically for charges based on percentages of fees for medical, hospital or lab services. So once you reach your individual and/or family deductible, the next level to consider is out-of-pocket maximum expenses. For example:

$10,000 ER visit
- 500 Deductible for individual coverage from an in-network provider
$ 9,500 Balance x 20% of ER charges remaining = $1,900

$3000 maximum out-of pocket
- 1900 for ER charges
$1,100 balance remaining to reach calendar year out-of-pocket maximum beyond co-pays

20. **Q: When I retire, can I still get health insurance through the City?**

A: It depends. If you are under 65, you can continue group health insurance at 100% of the premium cost. However, if you are over 65, you will be eligible for Medicare and should enroll in Medicare 3 months prior to your 65th birthday, the month of or 3 months after you turn 65. You may then elect COBRA coverage at your expense for dental and vision for three years only.

21. **Q: Where can I get additional information on CalPERS medical options?**

A: Visit www.calpers.ca.gov where there is a special section on Open Enrollment with links to useful information and publications.

22. **Q: How can I find out how much my dental bills will be ahead of time?**

A: If you are having dental work that will cost more than $200, ask the dentist to submit a pre-determination document prior to the service. Delta will notify you if the procedure will be covered, how much they will pay, and how much *you* will be responsible to pay.

Life Insurance

1. **Q: When can I increase the amount I have for life insurance?**

A: Only during Open Enrollment, which typically occurs in October each year.

2. **Q: When I increase my life insurance, does it go into effect the first of the Plan Year, for example on January 1?**

A: It depends. If you are approved before December 31 for the new Plan Year, coverage will be effective on January 1. However, if you do not receive underwriting approval by December 31, coverage becomes effective on the first day of the month following approval by the underwriter.

3. **Q: I got a Notice of Adverse Underwriting at home. What do I do?**
   A: Answer the question they have checked. Usually, there is some type of information that was missing from your life insurance application, and the company will indicate the data that is needed. Failure to do so may result in denial of additional life insurance.

4. **Q: How can I increase my life insurance coverage?**
   A: Complete a "Term Life Insurance Application"—All Parts (A, B C and D as appropriate). Be sure you to sign the second page of the form and have your spouse sign as well if you are applying for spousal coverage. You will also need to complete an Evidence of Insurability form.

5. **Q: How and when can I change my beneficiaries for my life insurance?**
   A: Complete a life insurance beneficiary form and return to Human Resources when you want to make the change. You do not need to wait until Open Enrollment. **NOTE**: You may also wish to change your beneficiaries at this time for CalPERS and for Payroll's issuance of your last check.

6. **Q: I am leaving employment with the City. Can I still keep my life insurance?**
   A: Yes. Portability rates are listed on SurfNet and are based upon your age at that time. You must make arrangements directly with the carrier who will set up billing you on a quarterly basis.

AD&D (Accidental Death & Dismemberment)

1. **Q: What is the difference between AD&D and life insurance?**
   A: Life insurance covers you in the event of death by paying your beneficiaries. AD&D, in addition to death, will pay based upon loss of limb or other debilitating situations as a result of an accident.

2. **Q: If I am injured in an accident, what amount will I receive?**
   A: It will depend on your injury and whether or not you have additional (supplemental) coverage. There is a sliding scale for various types of loss and depending upon your degree of disability.

3. **Q: What are the differences between Basic Life Insurance and Basis AD&D and Supplemental Life Insurance and Supplemental AD&D?**
   A: Basic coverage is paid for by the City for a $50,000 policy. Supplemental coverage is voluntary and at the employee's expense.

Long-Term Disability

1. **Q: How do you file a long-term disability claim?**
   A: Call CIGNA's toll free number at 1-800-362-4462 and a representative will walk you through the process and take all your information over the phone. You can also fill out the on-line claim form on www.CIGNA.com. Click on *Forms* at the bottom of their website home page.

2. **Q: When will I receive a LTD payment?**
   A: There is a 30-day waiting period for MEA, MEO, FMA and NA and 60-day waiting period for MSMA; and depending upon completeness of data, processing may be delayed. However, once approved, the first payment will be retroactive to the 31st day of being disabled.
3. **Q: What do I do for the first 30/60 days I am off work with no disability income?**
   A: You may use any leave accrual (sick leave, comp time or general leave) for the 30 days. If you do not have any leave balance, you may request voluntary donations for catastrophic leave through your department and Human Resources.
4. **Q: Since I am only receiving 2/3rds of my salary while on long-term disability, can I also use general leave to get paid 100%?**
   A: Yes, but you cannot use your general leave in such a way as to earn more than 100%. That is, you can take enough leave to equal 1/3 of your salary.

5. **Q: If I hurt myself at work, can I file for workers' compensation and long-term disability?**
   A: NO.

6. **Q: Are my long-term disability payments taxable?**
   A: Yes, it is considered "other income" per IRS regulations.

Employee Assistance Program (EAP)

1. **Q: What number do I call if I need to see a counselor?**
   A: 1-800-242-6220 or visit: members.mhn.com
   (Access Code/Password: huntingtonbch)

2. **Q: How many counseling sessions am I entitled to through the EAP?**
   A: You get 5 sessions per incident per family member per year. The sessions may be anywhere between half hour to one hour in length, depending upon the incident. The counseling sessions may be in person consultations or over the phone.

Flexible Spending Accounts (FSAs)

1. **Q: What kind of expenses can I claim through my Flexible Spending Account?**
   A: Check on SurfNet/Human Resources/Employee Benefits and scroll down to Flexible Spending Accounts (FSA's) where you will find a listing under "Eligible Expenses for Medical and Dependent Care" or visit http://ebsbenefits.com.

2. **Q: Once I sign up for an FSA, do I have to keep contributing the same amount each year?**
   A: No. In fact, you must re-enroll each year even if you want to contribute the same amount as in past years. However, you cannot change your decision in the middle of the Plan Year unless you have a change in status.

3. **Q: What is the limit I can set aside each year through an FSA to use pre-tax dollars to pay for health care and/or dependent care expenses?**
   A: It is $2,500 per calendar year for health care expenses and $5,000 per calendar year for dependent care expenses; but these limits may be reduced depending on an IRS non-discrimination test that the City must administer based upon the level of participation.

4. **Q: What happens if I do not use all of the money I set aside in my FSA account?**
   A: For the most part, it is a use it or lose it situation. You do, however, have a grace period typically to about March 15 for expenses incurred in the prior calendar year. Claims must be submitted by April 15. Otherwise, any remaining funds will be lost. There are no refunds or the ability to carry them forward.

Tuition Reimbursement

1. **Q: When do I apply for tuition reimbursement?**
   A: You must first complete Part A (available at http://surfnet/forms/templates/Education%20Reimbursement%20Form%20%20Part%20A%20Compatable.doc) of the tuition reimbursement form and get approvals from your department head and Human Resources **before** the class is scheduled to begin. **NOTE:** You will not be reimbursed for any expenses submitted after a class has been completed.

2. **Q: What do I need to submit to get a reimbursement?**
   A: With Part B of the form (available at http://surfnet/forms/templates/Education%20Reimbursement%20Form%20%20Part%20B%20Compatable.doc), you must attach the original of Part A Pre-approval that was returned to you authorizing participation in the program; receipts for registration, books and any fees; and proof of passing credit or a grade of C or better.

3. **Q: How do I get my reimbursement check?**
   A: You may either have your department payroll liaison give it to you when it is distributed or you may complete a direct deposit form with the City Treasurer's Office who will send you a "stub" notice when it has been processed.

4. **Q: How long will it take to get reimbursed?**
   A: The average processing time is two weeks for procedures handled through Human Resources, Purchasing and Accounts Payable.

5. **Q: I am in MEA and know I have a limit of $5,250 for tuition reimbursement per fiscal year. What portion will be taxed by the IRS?**
   A: Only the amount that was reimbursed over $5,250 in a calendar year. For example, if you were reimbursed for spring and summer semester for the limit allowed before October 1, and then reimbursed in December for $1,500 for a fall class, you would be liable for income taxes for the $1,500, which would be reimbursed through Payroll.

6. **Q: What is the maximum I can receive for tuition reimbursement?**
   A: It depends on your association. Refer to your MOU for limits, if any. MOUs are posted on SurfNet at http://www.huntingtonbeachca.gov/government/Departments/Human_Resources/mous/index.cfm

7. **Q: Can I receive reimbursement for classes taken on-line?**
   A: Yes, but they need to be given through an accredited university or college system.

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