2018

Part Time Employee Benefits Overview

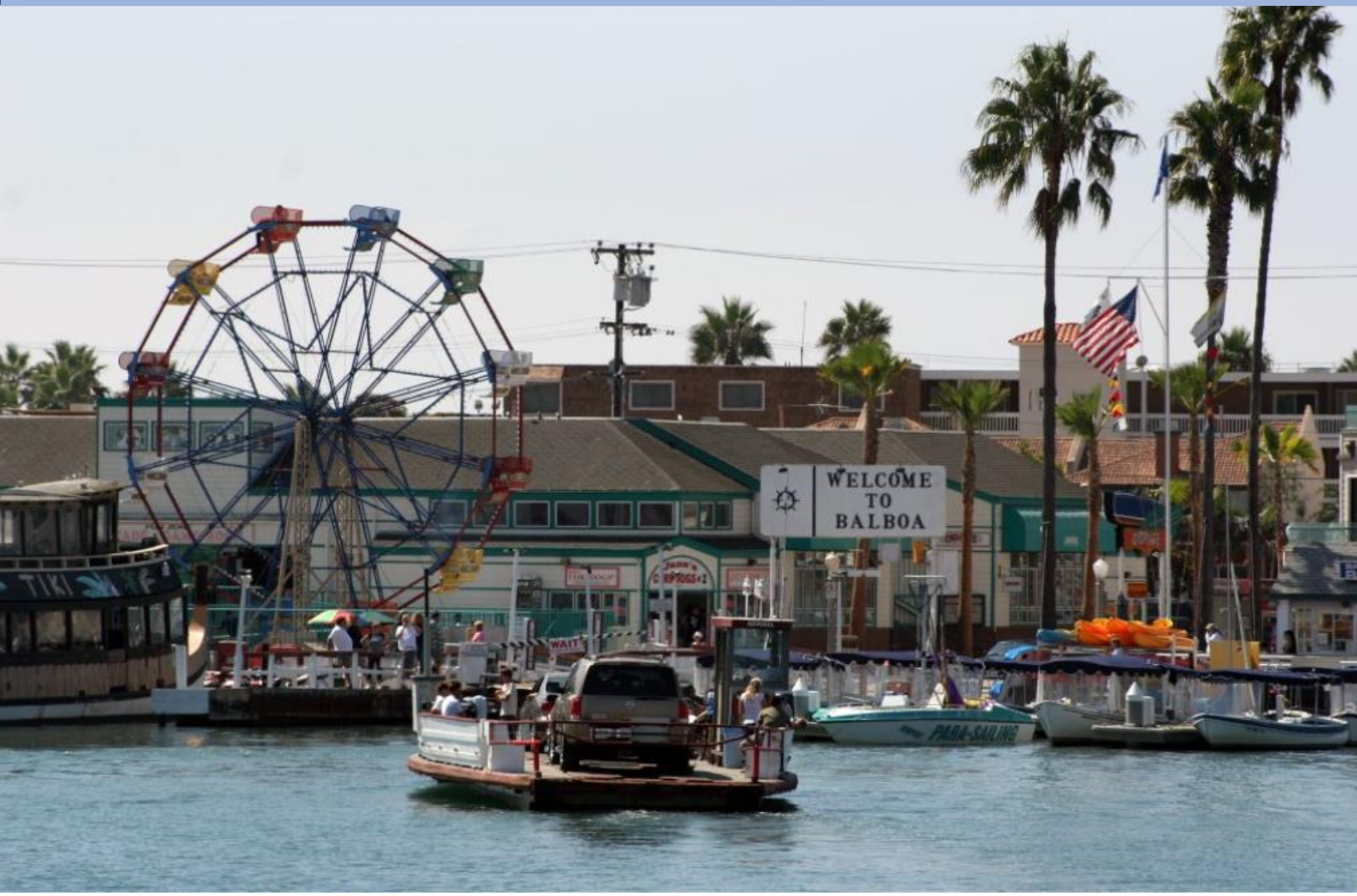

Table of Contents

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 14 for more details.

Welcome to the City of Newport Beach

At the City of Newport Beach, we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

A list of plan contacts is included at the back of this guide.

The benefits in this summary are effective:

January 1, 2018 - December 31, 2018

Open Enrollment Period

This booklet will give you information about the benefits which are available to you. Please read the information carefully. To help you make important decision about your benefits. Human Resources is available to answer any questions.

Open Enrollment

Beginning on Monday, September 11, 2017 and lasting through Friday, October 6, 2017, all plan participants will be eligible to participate in the annual Open Enrollment period. During Open Enrollment, you will be able to change group medical plans and add/or drop dependent coverage.

Your new plan benefits will be effective January 1, 2018 and will run through December 31, 2018. In order to ensure a smooth implementation, **you must make your changes through the Employee Self Service (ESS) no later than midnight on October 6, 2017. The opt-out waivers are due by 4:30pm on October 6, 2017. Proof of group coverage is due to Human Resources by December 9, 2017.**

Please call Human Resources if you have any questions at (949) 644-3256.

Helpful Hints

Read through this guide to familiarize yourself with what decisions you have to make. Think about your current benefit plans. Are they still working for you? Have you experienced any changes or do you anticipate any that might make a different plan more suitable?

Gather additional information. Use the websites and phone numbers on page 12 to see which doctors and other healthcare providers you can use under the different plan choices. If you have dependents on your plan that live out of state, check on provisions for coverage of members away from home.

Dependent Eligibility Verification

All employees adding/removing dependents must submit documentation to verify their dependent's eligibility and/or Qualifying Life Event. The following chart is an easy guide to what documents must be submitted along with the Health Enrollment/Change Form.

	Enrollment Form Required	Marriage Certificate Required	State of California Domestic Partner (DP) Registration	Birth Certificate/Certificate of Adoption Required	Social Security Number
Employee only	•				
Employee & Spouse	•	•			•
Employee & Domestic Partner (DP)	•	•	•		•
Employee & Children	•			•	•
Employee, Spouse/DP & Children	•	•	•	•	•

You are responsible for ensuring that the health enrollment information about you and your family members is accurate, and for reporting any changes in a timely manner. If you fail to maintain current and accurate health enrollment information, you may be liable for the reimbursement of health premiums of health care services incurred during the entire ineligibility period.

For example, if your divorce or dissolution occurred in 2015, yet you did not report it until 2017, your former spouse or domestic partner will be retroactive canceled from coverage effective the first of the month following the divorce or dissolution.

On page 5, you will find a detailed list of Qualifying Life Events, which must be reported to the HR department so we can make the appropriate change to your health coverage. **Qualifying Life Events changes must be made within 60 days from the date of the event.** Proper documentation is required, such as a copy of the marriage/domestic partnership certificate, birth/adoption certificate, or divorce/dissolution of domestic partnership decree.

When You Can Make Changes

Other than during the annual Open Enrollment period, you may not change your health coverage unless you experience a qualifying life event.

Qualifying life events include:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, dissolution of domestic partnership, and death of a spouse.
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child.
- Change in employment status, including the start or termination of employment by you, your spouse, or your dependent child.
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits.
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment.
- Change in an individual's eligibility for Medicare or Medicaid.
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child or dependent foster child.
- An event that is a qualifying life event under the Health Insurance Portability and Accountability Act (HIPAA), including acquisition of a new dependent or spouse or loss of coverage under another health insurance policy or plan if the coverage is terminated because of:
    - Voluntary or involuntary termination of employment or reduction in hours of employment or death, divorce, or legal separation;
    - Termination of employer contributions toward the other coverage, OR if the other coverage was COBRA Continuation Coverage, exhaustion of the coverage.

Important—Two rules apply to making changes to your benefits during the year:

- Any changes you make must be consistent with the change in status, AND
- You must make the changes within 60 days of the date the event occurs.

If you make mid-year changes to your insurance (adding/dropping dependents), contact Human Resources and provide supporting documents within 60 days of the change in status

Medical Benefits

The goal of the City of Newport Beach is to provide you with affordable, quality health care benefits. Our medical benefits are designed to help maintain wellness and protect you and your family from major financial hardship in the event of an illness or injury. The City offers a choice of medical plans through CalPERS medical program.

Anthem Blue Cross, Blue Shield, Kaiser Permanente and United Healthcare

Health Maintenance Organization (HMO)

Under the HMO plans, most services and medicines are covered with a small copayment. You select a Primary Care Physician (PCP) to coordinate your care. You have a choice between the CalPERS Anthem Blue Cross Select, Anthem Blue Cross Traditional, Blue Shield Access+, Health Net SmartCare, Kaiser Permanente and UnitedHealthcare Alliance HMO plans.

Anthem Blue Cross

Preferred Provider Organization (PPO)

The Anthem Blue Cross PPO plan is designed to provide choice, flexibility and value. The PPO plan is a managed care organization of medical doctors, hospitals, and other health care providers who have contracted with Anthem Blue Cross to provide health care at reduced rates to you. Participants have a choice of using network providers or going directly to any other physician (non-network provider) without a referral. There is an annual deductible to meet before benefits apply. You are also responsible for a certain percentage of the charges (coinsurance), and the plan pays the balance up to the agreed upon amount. You have a choice between the CalPERS Anthem Blue Cross—PERS Choice, PERS Select, and PERSCare plans.

In order to ensure a smooth implementation, you must make your changes through Employee Self Service (ESS) no later than midnight on October 6, 2017. The opt-out waivers are due by 4:30pm on October 6, 2017.

Why Would I Choose a PPO Plan?	Why Would I Not Choose a PPO Plan?
• You have a doctor you like and you would like to keep this doctor. • You want to see specialists and other providers without having to first get a referral and/or pre-approval. • You want the freedom to see providers who are not in the network. • You are confident that you can manage your own care. • You do not want a primary care doctor.	• You do not want the extra responsibility of managing your own care. • PPOs are not as closely regulated by the government as HMOs. • You do not want to pay the higher costs of a PPO. • You do not want to get bills from providers.

2018 CalPERS Basic Medical Plans Comparison Chart

	CalPERS HMO	CalPERS Kaiser HMO	CalPERS Select PPO & PERSChoice PPO*	
	Anthem, Blue Shield, Health Net, Sharp, UnitedHealthCare	Kaiser	In-Network	Out-of-Network
Calendar Year Deductible	None	None	$500 individual $1,000 family (combined)	
Out of Pocket Maximum	$1,500 individual $3,000 family	$1,500 individual $3,000 family	$3,000 individual $6,000 family	None
Physician Office Visits (including Mental Health & Substance Abuse)	$15 copay/ visit	$15 copay/ visit	$20 copay/ visit	You pay 40%
Diagnostic Lab & X-ray	No Charge	No Charge	You pay 20%	You pay 40%
Emergency Room	$50 copay/ visit; waived if admitted	$50 copay/ visit; waived if admitted	You pay 20% after $50 deductible	You pay 20% after $50 deductible
Urgent Care (non-emergency)	$15 copay/ visit	$15 copay/ visit	You pay 20%	You pay 40%
Hospital Services (including Mental Health & Substance Abuse)	No Charge	No charge $15 Outpatient Facilities/ Surgery Services	You pay 20% 20%-30% (PERS Select only) Hospital Tiers	You pay 40%
Chiropractic/ Acupuncture (combined)	$15 copay/ visit up to 20 visits per calendar year (combined)	$15 copay/ visit up to 20 visits per calendar year (combined)	$15 copay/ visit up to 20 visits per calendar year (combined)	You pay 40%
Durable Medical Equipment	No Charge	No Charge	You pay 20% Pre-certification required	You pay 40% Pre-certification required
Prescription	30-day supply[4]	30-day supply	30-day supply[1,2,3]	30-day supply[1,2,3]
Generic	$5 copay	$5 copay	$5 copay	$5 copay
Brand	$20 copay	$20 copay	$20 copay	$20 copay
Non-formulary	$50 copay	N/A	$50 copay	$50 copay
Mail Order	90-day supply	31-100 day supply	90-day supply	90-day supply
Generic	$10 copay	$10 copay	$10 copay	$10 copay
Brand	$40 copay	$40 copay	$40 copay	$40 copay
Non-formulary	$100 copay	N/A	$100 copay	$100 copay

*Administered by Blue Cross [1]OptumRX provides prescription drug benefit management services for PERS Select, Choice & Care. These services include administration of the Retail Pharmacy Program and the Mail Service Program; delivery of specialty pharmacy products such as biotechs and injectables; clinical pharmacist consultation; and clinical collaboration with your physician to ensure you receive optimal total healthcare. [2]Mandatory generic substitution; if a brand name is requested when generic is available you will be responsible for generic copay and the difference between the generic and brand name. [3]Self-administered injectable medications are available under your pharmacy benefits and are no longer payable under the medical benefit. [4]Mandatory mail service for maintenance drugs. Mail Service would be mandatory after the 2nd fill of RX at retail pharmacy, OR Member will be charged the appropriate mail service copay for a one-month supply at retail. These benefit summaries only highlight your benefits. They are not summary plan descriptions (SPDs**). If any discrepancy exists between this summary and the official documents, the official documents will prevail.**

2018 CalPERS Basic Medical Plans Comparison Chart

CalPERS PERSCare PPO*	
In-Network	**Out-of-Network**
$500 individual $1,000 family (combined)	
$2,000 individual $4,000 family	None
$20 copay/ visit	You pay 40%
You pay 10%	You pay 40%
You pay 10% after $50 deductible You pay 10%	You pay 10% after $50 deductible You pay 40%
You pay 10% ($250/admission inpatient facility deductible)	You pay 40% ($250/admission inpatient facility deductible)
$15 copay/ visit up to 20 visits per calendar year (combined)	You pay 40%
You pay 10% Pre-certification required	You pay 40% Pre-certification required
34-day supply[1,2,3] $5 copay $20 copay $50 copay	34-day supply[1,2,3] $5 copay $20 copay $50 copay
90-day supply $10 copay $40 copay $100 copay	90-day supply $10 copay $40 copay $100 copay

2018 Monthly Premium Rates - Active

Other Southern California Region – Orange, Riverside, San Diego, Fresno, Imperial, Inyo, Kern, Kings, Madera, San Luis Obispo, Santa Barbara and Tulare Counties:

PERS HMO Plans

Medical Plan	Single	2-Party	Family
Anthem Select HMO	$659.69	$1,319.38	$1,715.19
Anthem Traditional HMO	$735.08	$1,470.16	$1,911.21
Blue Shield Access+ HMO	$695.97	$1,391.94	$1,809.52
Health Net Salud y Mas HMO	$461.56	$923.12	$1,200.06
Health Net SmartCare HMO	$607.68	$1,215.36	$1,579.97
Kaiser (CA) HMO	$666.80	$1,333.60	$1,733.68
Sharp HMO	$618.14	$1,236.28	$1,607.16
UnitedHealthcare HMO	$616.66	$1,233.32	$1,603.32

PERS PPO Plans

Medical Plan	Single	2-Party	Family
PERS Choice PPO	$698.96	$1,397.92	$1,817.30
PERS Select PPO	$654.74	$1,309.48	$1,702.32
PERS Care PPO	$733.50	$1,467.00	$1,907.10

2018 Monthly Premium Rates - Active

Los Angeles Area – Los Angeles, San Bernardino and Ventura Counties:

You may choose from one of the following plans if you reside in one of the Los Angeles Area counties AND wish to receive your medical services in the same county.

PERS HMO Plans

Medical Plan	Single	2-Party	Family
Anthem Select HMO	$660.17	$1,320.34	$1,716.44
Anthem Traditional HMO	$784.72	$1,569.44	$2,040.27
Blue Shield Access+ HMO	$613.29	$1,226.58	$1,594.55
Health Net Salud y Mas HMO	$404.32	$808.64	$1,051.23
Health Net SmartCare HMO	$577.15	$1,154.30	$1,500.59
Kaiser (CA) HMO	$642.70	$1,285.40	$1,671.02
UnitedHealthcare HMO	$602.78	$1,205.56	$1,567.23

PERS PPO Plans

Medical Plan	Single	2-Party	Family
PERS Choice PPO	$620.39	$1,240.78	$1,613.01
PERS Select PPO	$573.21	$1,146.42	$1,490.35
PERS Care PPO	$673.73	$1,347.46	$1,751.70

Cafeteria Contribution's

Level 1

PTEANB membership prior to July 1, 2014

Hours Work Per Week*	Cafeteria Medical Benefit	Waive/Opt-Out Benefit
30 or more	$775.00 per month	$334.00 per month
Less than 30	$4.25 per hour worked, max of 60 pay period	$3.25 per hour worked, max of 60 pay period

Level II

PTEANB membership between July 1, 2014 and December 31, 2016

Hours Work Per Week*	Cafeteria Medical Benefit	Waive/Opt-Out Benefit
30 or more	$550.00 per month	N/A
Less than 30	$4.25 per hour worked, max of 60 pay period	N/A

*Based on the City's measurement period as required under the Affordable Care Act. Employees will be notified annually whether they meet the 30 hours threshold.

Plan Contacts

Contact your health plan with questions about ID cards; verification of provider participation; service area boundaries (covered zip codes): benefits, deductible, limitations, exclusion; and Evidence of Coverage booklets.

Plan Type	Provider	Phone Number	Website
Select HMO Traditional HMO	Anthem Blue Cross	Member Services: 855-839-4524 RX-OptumRX: 855-505-8110	www.anthem.com/ca/calpers/hmo www.optumrx.com/calpers
Access+ and NetValue HMO	Blue Shield	Member Services: 800-334-5847 Rx, CVS Caremark: 866-346-7200	www.blueshieldca.com/calpers www.caremark.com/CalPERS
HMO	Health Net	Member Services: 888-926-4921 Rx- OptumRx: 855-505-8110	www.healthnet.com/calpers www.optumrx.com/calpers
HMO	Kaiser Permanente	Member Services: 800-464-4000	www.kp.org/ca/calpers
HMO	Sharp	Member Services: 855-955-5004 Rx- OptumRx: 855-5058110	www.sharphealthplan.com/calpers www.optumrx.com/calpers
Alliance HMO	UnitedHealthcare	Member Services: 877-359-3714 Rx- OptumRx: 855-505-8110	www.uhc.com/calpers www.optumrx.com/calpers
PERS Care PPO PERS Choice PPO PERS Select PPO	Anthem Blue Cross	Member Services: 877-737-7776 Rx- OptumRx: 855-505-8110	www.anthem.com/ca/calpers www.optumrx.com/calpers
Anthem Blue Cross	PORAC PPO	Member Services: 800-288-6928 Rx- Express Scripts: 866-470-6265	www.porac.org www.express-scripts.com
Other Contacts	CalPERS PARS Empower Retirement	Members: 888-225-7377 Members: 800-540-6369 Participants: 800-701-8255	www.calpers.ca.gov www.pars.org www.empower-retirement.com

Required Federal Notices

NOTICE OF AVAILABILITY OF HIPAA PRIVACY NOTICE

The Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we periodically remind you of your right to receive a copy of the HIPAA Privacy Notice. You can request a copy of the Privacy Notice by contacting the Employee Benefits Customer Service Center.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR MEDICAL/HEALTH PLAN COVERAGE

If you decline enrollment in a City of Newport Beach health plan for 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 an City of Newport Beach 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 30days 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 Newport Beach medical plan if your dependent becomes 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.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the same deductible and co-payments applicable to other medical and surgical benefits provided under this plan. You can contact your health plan's Member Services for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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.

Required Federal Notices

AVAILABILITY OF SUMMARY INFORMATION

As an employee, the health benefits provided by City of Newport Beach represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

City of Newport Beach offers a variety of benefit plans to eligible employees. The federal healthcare reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan. SBCs and any revisions or amendments of the plans offered by are available on our portal (if applicable) or by contacting your Human Resources/Benefits Department.

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 their network and who is available to accept you or your family members. Until you make this designation, your carrier will designate 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.

Important Notice About Your Prescription Drug Coverage and Medicare Applies only if you have a Medicare Eligible Dependent

MEDICARE PART D (Prescription Drug) through CalPERS

Medicare Part D is a voluntary federal outpatient prescription drug benefit available to everyone with Medicare. The Medicare Part D premium varies based on the prescription drug plan and is paid to your health carrier as part of the CalPERS health premium. As with Medicare Part B, if your income exceeds established thresholds, the SSA will assess an additional income-related monthly adjustment amount. Payment of this amount is mandatory to protect your Medicare enrollment and eligibility to remain enrolled in a CalPERS Medicare health plan.

To be enrolled in a CalPERS Medicare health plan, you cannot be enrolled in a non-CalPERS Medicare Part D plan. CalPERS Health Plans and Medicare Part D CalPERS participates in the Employer Group Waiver Plan (EGWP). EGWPs are Prescription Drug Plans governed by the CMS. If you are a Medicare-eligible subscriber or dependent, you are automatically enrolled into EGWP. If for some reason, you chose to opt out of EGWP, you will be financially responsible for all of your prescription drug costs. In addition, if you enroll in a non-CalPERS Medicare Part D plan, you are no longer eligible to remain enrolled in a CalPERS Medicare health plan. Consequently, you and all of your covered dependents will be terminated.
Contact the City of Newport Beach Human Resources Department for more details.

Required Federal Notices

DO NOT ENROLL IN A NON-CALPERS MEDICARE PLAN PART D

Your CalPERS coverage includes enrollment in a Medicare Part D Plan. Do not enroll in a non-CalPERS Medicare Part D plan. If you or your dependents are covered by CalPERS and another health plan that includes Medicare Part D prescription drug benefits, you must cancel that Part D coverage to enroll in, or continue enrollment in a CalPERS Medicare health plan.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The City of Newport 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:

- 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.
- The City has determined that the prescription drug coverage offered by the City of Newport Beach 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 15 through December 7. 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 do decide to join a Medicare drug plan and drop your current City prescription drug coverage, be aware that you and your dependents will may not be able to get this coverage back.

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with The City of Newport Beach and do not 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 City of Newport Beach Human Resources Department.

Required Federal Notices

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 the City 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 www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2018
Name of Entity: City of Newport Beach
Contact: Human Resources
Address: 100 Civic Center Drive, Newport Beach, CA 92660
Phone: (949) 644-3256

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**

Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	IOWA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website:http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300

NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: https://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Notes

Rev. 9/1/2017