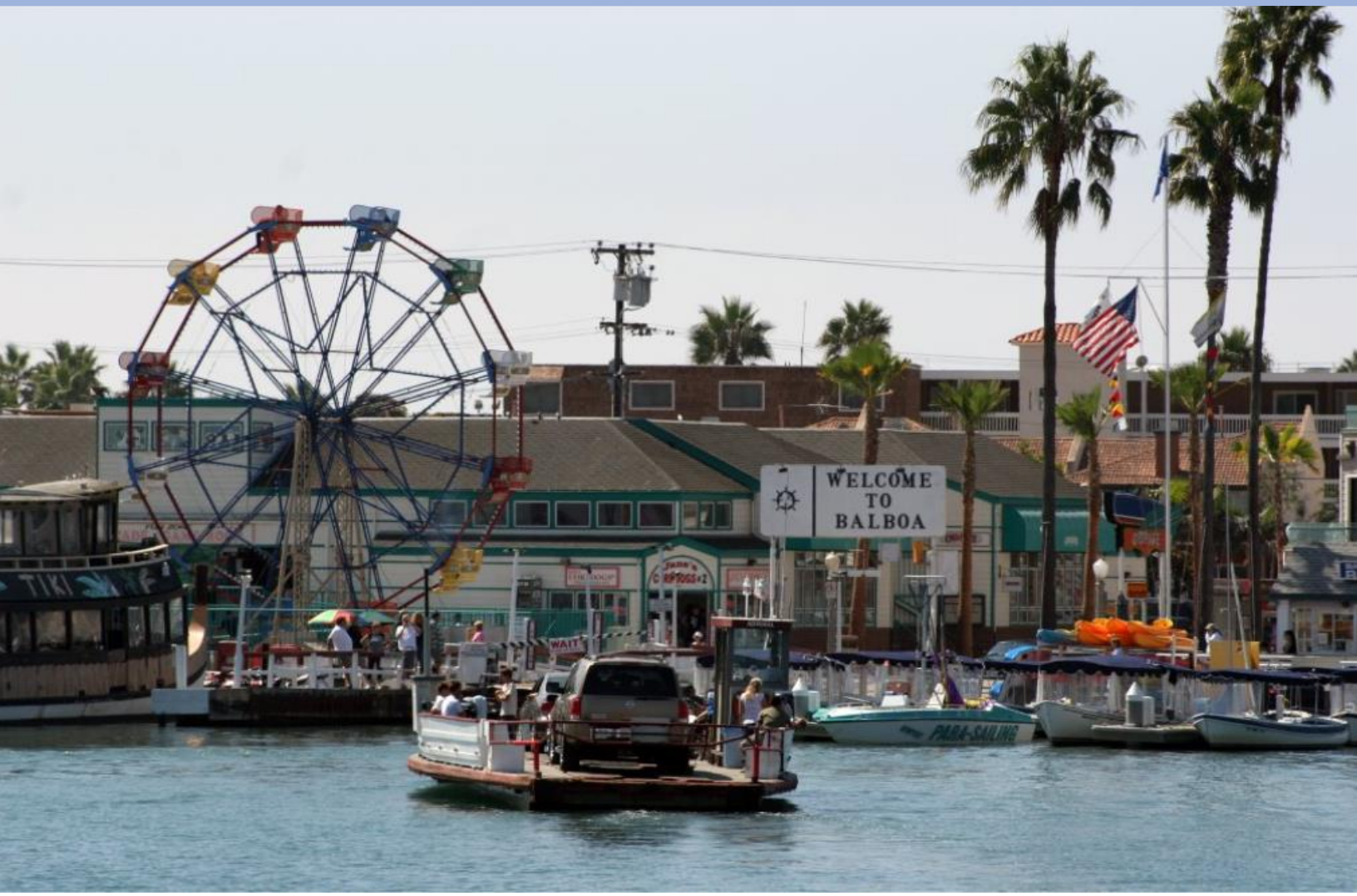
2018

Full Time Employee Benefits Overview



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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 20 & 21 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 10, 2018 and lasting through Friday, October 5, 2018, 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, 2019 and will run through December 31, 2019. In order to ensure a smooth implementation, **you must make your changes through the Employee Self Service (ESS) no later than midnight on October 5, 2018. The opt-out waivers are due by 4:30pm on October 5, 2018. Proof of group coverage is due to Human Resources by December 7, 2018.**

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

Helpful Hints

Read 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 18 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 and costs 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 would 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, FSA or Dependent Care elections 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, including Flexible Spending Account and Dependent Care Account 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, PERSCare, and PORAC plans. (PORAC is available to dues paying members in the Police and Fire bargaining units)

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

2018 CalPERS Basic Medical Plans Comparison Chart

CalPERS PERSCare PPO*		CalPERS PORAC PPO*	
In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
$500 individual $1,000 family (combined)		$300 individual $900 family	$600 individual $1,800 family
$2,000 individual $4,000 family	None	$3,300 individual $6,600 family	None
$20 copay/ visit	You pay 40%	$20 copay/ visit	You pay 10%
You pay 10%	You pay 40%	You pay 10%	You pay 10%
You pay 10% after $50 deductible You pay 10%	You pay 10% after $50 deductible You pay 40%	You pay 10% You pay 50%	
You pay 10% ($250/admission inpatient facility deductible)	You pay 40% ($250/admission inpatient facility deductible)	You pay 10%	You pay 10%
$15 copay/ visit up to 20 visits per calendar year (combined)	You pay 40%	Acupuncture: $20/10% after copay Chiropractic: Up to 20 visits/calendar year	Acupuncture: 10% Chiropractic: $35/ visit
You pay 10% Pre-certification required	You pay 40% Pre-certification required	You pay 20%	You pay 20%
34-day supply[1,2,3] $5 copay $20 copay $50 copay	34-day supply[1,2,3] $5 copay $20 copay $50 copay	34-day supply or 100/pills, whichever is more $10 copay $25 copay $45 copay Compound: $45	 $10 copay $25 copay $45 copay Compound: $45
90-day supply $10 copay $40 copay $100 copay	90-day supply $10 copay $40 copay $100 copay	 $20 copay $40 copay $75 copay	N/A

*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 Monthly Contributions/Premium Rates - Active

Cafeteria & Medical Allowance Contributions

Association/Bargaining Unit	Cafeteria Allowance		Medical Allowance (must enroll in a health plan to receive)
	Contribution	Opt-Out Amount	Contribution
CEA, K&M & Prof/Tech	$1,725.00	$1,000.00	$133.00
FA & FMA	$1,624.00	$1,000.00	$133.00
League	$1,725.00	$1,000.00	$133.00
LMA	$1,624.00	$1,000.00	$133.00
PA & PMA	$1,524.00	$1,000.00	$133.00

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
PORAC PPO	$734.00	$1,540.00	$1,970.00

2018 Monthly Contributions/Premium Rates – Active,

Dental & Vision Plans

Dental/Vision Plan	Single	2-Party	Family
Cigna Dental DHMO	$13.32	$23.96	$36.07
Cigna Dental PPO	$54.69	$111.30	$153.05
MES PPO Vision	$7.30	$13.99	$19.99

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
PORAC PPO	$734.00	$1,540.00	$1,970.00

Vision

Routine vision exams can not only correct vision, but also detect more serious health conditions.

	MES Vision Plan	
	In-Network	**Out-Of-Network**
Examination **Benefit** **Frequency**	 $10 copay then plan pays 100% 1 x every 12 months from last date of service	 Plan pays 100% (reimbursed up to $40) In-network limitations apply
Materials	Plan pays 100%	Plan pays 100% (see schedule below)
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	 Plan pays 100% of basic lens Plan pays 100% of basic lens Plan pays 100% of basic lens 1 x every 12 months from last date of service	 Reimbursed up to $30 Reimbursed up to $50 Reimbursed up to $65 In-network limitations apply
Frames **Benefit** **Frequency**	 $100 allowance 1 x every 12 months from last date of service	 Reimbursed up to $40 In-network limitations apply
Contacts (Elective) **Benefit** **Frequency**	 Reimbursed up to $105 balance (instead of eyeglasses) 1 x every 12 months from last date of service	 Up to $105 (in-network limitations apply) In-network limitations apply

Dental

Regular visits to your dentists 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.

	Cigna Dental PPO	
	In-Network	**Out-Of-Network**
Calendar Year Deductible	$0 per individual $0 family limit	$50 per individual $150 family limit
Annual Plan Maximum	$2,000	$2,000 (combined with in-network)
Waiting Period	None	None
Diagnostic and Preventive	Plan pays 100%	Plan pays 100%
Basic Services Fillings Root Canals Periodontics	 Plan pays 90% Plan pays 90% Plan pays 90%	 Plan pays 80% after deductible Plan pays 80% after deductible Plan pays 80% after deductible
Major Services	Plan pays 60%	Plan pays 50% after deductible
Orthodontic Services Orthodontia Lifetime Maximum Dependent Children Full-time Students	 Plan pays 50% $2,000 Covered Covered	 Plan pays 50% $2,000 Covered Covered

Dental, continued

	Cigna Dental HMO Plan
	In-Network
Calendar Year Deductible	$0 per individual $0 family limit
Annual Plan Maximum	Unlimited
Diagnostic and Preventive	$0 - $240 (varies by services, see contract for fee schedule) copay then plan pays 100%
Basic Services	
Fillings	$0 - $145 (varies by services, see contract for fee schedule) copay then plan pays 100%
Root Canals	$0 - $155 (varies by services, see contract for fee schedule) copay then plan pays 100%
Periodontics	$0 - $255 (varies by services, see contract for fee schedule) copay then plan pays 100%
Major Services	$0 - $620 (varies by services, see contract for fee schedule) copay then plan pays 100%
Orthodontic Services	
Orthodontia	$1,100 to age 19 and $1,600 over age 19
Lifetime Maximum	Unlimited
Dependent Children	Covered
Full-time Students	Covered

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 and pay for large expenses such as housing and education, as well as day-to-day living expenses.

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	1 x covered annual earning up to a maximum of $50,000
Basic AD&D Amount	1 x covered annual earning up to a maximum of $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	Increment of $10,000 up to $500,000
Spouse Voluntary Life Amount	Increment of $10,000 up to Lesser of plan pays 100% of employee amount or $500,000
Child(ren) Voluntary Life Amount	Birth to 6 months: $1,000; $2,500 6 months to 26 years: increments of up to Birth to 6 months: $1,000; 6 months to 26 years: $10,000

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: If you select a coverage amount above a certain limit, you will need to submit an Evidence of Insurability form with additional information about your health in order for the insurance company to approve this higher amount of coverage.

How to I apply for Voluntary Life Insurance: Inquire with Human Resources during Open Enrollment if you wish to apply for voluntary life insurance.

Disability

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.

SHORT-TERM DISABILITY INSURANCE

Short-Term Disability (STD) coverage pays you a benefit if you temporarily cannot work because of an injury, illness, or maternity leave. Benefits may be reduced by income from other income sources such as paid time off. Your doctor and the insurance company will work together to determine how long benefits are payable, based on your condition. Coverage is provided by CIGNA Group.

Weekly Benefit Amount	Plan pays 66 2/3% of covered weekly earnings
Maximum Weekly Benefit	$1,846
Benefits Begin After:	
Accident	30 days of disability
Sickness	30 days of disability
Maximum Payment Period	150 days

- Benefit waiting period is 30 days for accident, sickness or pregnancy.
- The plan benefit is 66 2/3% to a maximum weekly benefit of $1,846. The benefit will be reduced by Workers Compensation or any earring or compensation you are eligible to receive while on STD.
- Maximum Benefit Period is 150 days.
- Twenty-Four hour coverage is provided for both Occupation and Non-Occupation Disabilities.

LONG TERM DISABILITY

Long-Term Disability (LTD) 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. If you qualify, long-term disability benefits begin after short-term disability benefits end. Coverage is provided by CIGNA Group.

Monthly Benefit Amount	Plan pays 66 2/3% of covered monthly earnings
Maximum Monthly Benefit	$15,000
Benefits Begin After:	
Accident	180 days of disability
Sickness	180 days of disability
Maximum Payment Period	Age 65 (changes based on disability date)

- Benefit Waiting Period is 180 days of disability.
- The LTD benefit is 66 2/3 of the first $15,000 of your monthly pre disability earrings reduced by deductible income. $15,000 is the maximum monthly benefit. The monthly benefit is reduced by Workers Compensation, PERS, Social Security and other income sources.
- Once approved, benefit are payable each month while you are disabled up to the age 65. This benefit is graded if disabled after age 62.
- A three month survivor benefit is payable to a surviving spouse/domestic partner or child if you died while receiving benefits.
- Partial Disability is allowed during both the benefit waiting period and while benefits are payable.
- Mental/Nervous, Substance Abuse and other limited condition disabilities are covered for 24 months during your lifetime.
- A pre-existing condition exclusion with a 90-day pre-existing condition period 12 month exclusion period is included.
- Conversion of insurance is included.

Flexible Spending Account (Administered by WORKTERRA)

The Flexible Spending Accounts (FSA) are a great way to use pre-tax dollars to pay for expenses paid with after-tax dollars! You may enroll in either or both the Healthcare Spending Account or the Dependent Care Spending Account. These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts. Money from these accounts is then used to pay eligible expenses that are not reimbursed by your health plans, as well as reimbursement for dependent care expenses.

Pre-tax means the dollars you allocate toward these accounts are not subject to Social Security tax, Federal income tax and, in most cases, state and local taxes. The money you set aside may be used for qualified eligible expenses on a pre-tax basis. At enrollment, you determine the amount of money to contribute to one or both of these accounts for the City's plan year. The contributions are deducted pre-tax from your paycheck per pay period and deposited into your FSA account(s). You request reimbursement of qualified expenses from your FSA account(s) as you incur the expenses. **USE IT OR LOSE IT!**

Dependent Care Spending Account

The maximum amount you may contribute to the Dependent Care Spending Account is $5,000 each calendar year, or **$2,500** each calendar year if you are married but file separate tax returns. This account will reimburse you with pre-tax dollars for daycare expenses for your child(ren) and other qualifying dependents. These include expenses for childcare or dependent adult care for a member of your household.

Eligible Dependents Include:

- Children under the age of 13 who qualify as dependents on your Federal tax return; and
- Children or other dependents of any age who are physically or mentally unable to care for themselves and who qualify as dependents on your Federal tax return. You may use the Federal childcare tax credit and the Dependent Care Spending Account; however, your Federal credit will be offset by any amount deferred into dependent care plan.

Healthcare Spending Account

The maximum amount you may contribute to the Healthcare Spending Account for the Plan Year is **$2,650.** This account will reimburse you with pre-tax dollars for qualified out-of-pocket healthcare expenses not covered under your family's healthcare plans. The "Use it or Lose it" rule applies if you do not incur expenses by December 31, 2018 of the plan year following your contributions, you lose the unexpended portion. **USE IT OR LOSE IT!**

Medical-related expenses include out of pocket money for copays or deductibles for medical, dental and vision services. A detailed listing of all qualified expenses are available on the WORKTERRA website at http://workterra.com/member-center.com.

Note: FSA elections are not automatic. You must re-enroll during Open Enrollment to participate in the FSA for the 2018 plan year.

Please estimate your annual contributions carefully! If you do not use all the money in your account by December 31, 2018 you will forfeit funds left in the account. Participants will have until March 31 of the following plan year to submit claims for expenses incurred during eligible plan year.

Request to change elected amounts after January 1 will be considered subject to the administration of Qualifying Events, see page 5 for Qualifying Event Rules.

Other Programs

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 is free.

Help is available 24/7, 365 days a year by telephone at 800-322-9707. Other resources are available online at members.mhn.com. Company Code: Newport

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 3 sessions per year.

Additional benefits are available through your medical plan. Review your medical benefit summary for more information.

The EAP can support you with:

- Smoking Cessations
- Stress Management
- Weight Management
- Dependent care assistance
- Identify theft assistance
- Financial consolation
- Legal consultation
- Personal wellness coaching
- Marriage and Relationship
- Greif and Loss

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+ 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
Cigna	DPO and DMO	Member Services: 800-244-6224	www.mycigna.com
MES	Vision	Member Services: 800-877-6372	www.mesvision.com
Cigna	Basic Life/AD&D, Vol Life/AD&D, LTD	Member Services: 800-362-4462	www.mycigna.com
Cigna	STD	Member Services: 800-362-4462	www.mycigna.com
MHN, Inc.	Employee Assistance Program (EAP)	Member Services: 800-322-9707	members.mhn.com
WORKTERRA	WORKTERRA - Flexible Spending Accounts and COBRA	Member Services: 888-327-2770	http://workterra.com/member-center.com
Other Contacts	CalPERS ICMA-RC Empower Retirement	Members: 888-225-7377 RHS: 800-669-7400 Participants: 800-701-8255	www.calpers.ca.gov www.icmarc.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 Human Resources.

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

If you decline enrollment in an 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 a 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 30 days after the loss of other coverage.
- Gain a new dependent because 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 health 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.
Note: If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another health plan.

AVAILABILITY OF SUMMARY INFORMATION

We maintain the HIPAA Notice of Privacy Practices for City of Newport 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 City of Newport Beach

WOMEN'S HEALTH AND CANCER RIGHT

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 our plans. If you would like more information on WHCRA benefits, call your plan administrator.

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

NEWBORN 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.

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.

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 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 City of Newport Beach Human Resources Department.

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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. 7/16/2018