2023

COUNCIL MEMBERS BENEFITS OVERVIEW

BENEFITS FOR EVERY STEP OF YOUR JOURNEY

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 Important Plan Information section for more details.

GETTING STARTED

2023 BENEFITS
January 1st, 2023
through
December 31st, 2023

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, The City of Huntington Beach supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

WHO'S ELIGIBLE FOR BENEFITS?

Council Members

Council Members are eligible for the benefits outlined in this overview.

Eligible dependents

- Legally married spouse
- Your registered same or opposite sex domestic partner is eligible for coverage. Any premiums for your domestic partner paid for by The City of Huntington Beach are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26
- Children over age 26 who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO)

For additional information, please refer to the benefit booklets for each benefit.

Who is not eligible

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

- Parents, grandparents, and siblings

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first of the month following date of hire. New Council Members must enroll within 31 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

OPEN ENROLLMENT

Open Enrollment is a once-a-year opportunity to review your benefit choices, change plans, add or drop dependents, and enroll or re-enroll in Flexible Spending Accounts. After Open Enrollment ends, you cannot change your benefit elections until the next Open Enrollment in 2024 unless you experience an eligible life event.

Open Enrollment begins October 1st, 2022 through October 31st, 2022.

Any changes made during OE will be effective on January 1st, 2023.

Do I need to enroll?

If you do not have any changes to make to your 2023 benefits and you do not want to enroll in a 2023 Flexible Spending Account, **no action is required.**

What's new or changing

Our current benefit program will continue into 2023. While your benefits aren't changing, you may have had some major life changes. Do your current choices still meet your needs? Review this benefits guide to understand your coverage options. Include your spouse or partner in the review if they have input into your family's benefits decisions.

These changes will be effective on January 1st, 2023.

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 30 days of the date the event occurs.
3. All proper documentation is required to cover dependents(marriage certificates, birth certificates, etc.).

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP)

You must submit your change within 30 days after the event.

Dependent Verification

Making changes to dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You will be required to provide proof of one or more of the following within 30 days of their eligibility:

- Marriage Certificate or License
- Domestic Partner Affidavit
- Birth Certificate
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)

If you do not supply the proper documentation to make changes to dependents within the 30-day period, you will not be able to add the dependent(s) until you experience an additional QLE or the next open enrollment period.

ENROLLING FOR BENEFITS

MID YEAR CHANGES

- You have year-round access to a summary of your benefits through WorkTerra.
- Mid year changes should be initiated by contacting Human Resources.

WORKTERRA

(self service enrollment is available only during open enrollment. Any new hires or QLE's must submit enrollment forms to HR)

WORKTERRA is an online system that enables you to make all your benefit decisions in one place.

If you don't have access to a computer, you can access the enrollment portal from a tablet or smartphone.

Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.
- Before entering the ESS webpage, be sure to turn off any pop-up blockers that you may have installed on your computer. Pop-up blockers can interfere with the proper operation of the course.

Getting started

- LOG IN to WORKTERRA.

  Username: Your username is the first initial of your first name, full last name and first four digits of your date of birth – month and day [Example: jsmith0717].

  Password: Your initial password is your full last name and the last four digits of your social security number [Example: smith5679].

  For company name, enter City of Huntington Beach.

  For safety purposes, you will be prompted to change your password after your initial login.
- ADD your personal and dependent information.
- SELECT your benefit plans for the coming year.
- REVIEW your choices and costs before finalizing.
- COMPLETE: Once you have finished reviewing, please be sure to click *"Finish",* if you do not do so your elections will not be recorded, and your Open Enrollment will **not** be completed.

MEDICAL

OUR PLANS

KAISER HMO

BLUE SHIELD TRIO (HMO)

BLUE SHIELD ACCESS+ (HMO)

BLUE SHIELD PPO

BLUE SHIELD HDHP

Insurance Lingo

Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

Do you prefer specific doctors or hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

Consider the bottom line

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

WHICH PLAN IS RIGHT FOR YOU?

Consider an HMO (Health Maintenance Organization) if:

- You want lower, predictable out-of-pocket costs
- You like having one doctor to manage your care
- You are happy with the selection of network providers
- You don't see any doctors that are out-of-network
- You have convenient access to Kaiser facilities (Kaiser HMO plan only)

Plans To Consider

- Kaiser HMO
- Blue Shield Access+ HMO
- Blue Shield Trio HMO

Consider a PPO (Preferred Provider Organization) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers

Plans To Consider

- Blue Shield PPO

Consider a High Deductible Health Plan (HDHP) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers
- You want tax-free savings on your healthcare costs
- You want to build a savings account for future healthcare costs for you and your eligible family members
- You want an extra way to add to your retirement savings

Plans To Consider

- Blue Shield HDHP

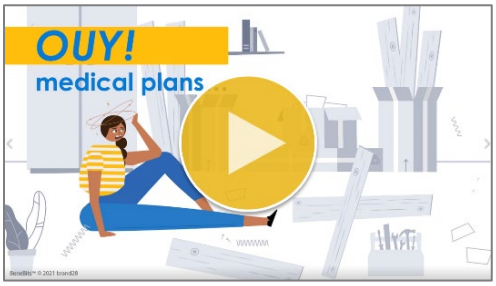
UNDERSTANDING PLAN TYPES

The City of Huntington Beach offers 3 medical plan types so that you can pick the plan that best fits your budget and healthcare needs.

Some plans (like HMOs) restrict you to in-network doctors. Other plans (like PPOs) allow you to see any doctor, but you will pay a higher coinsurance percentage if the doctor is out-of-network.

	HMO Health Maintenance Organization	**PPO** Preferred Provider Organization	**HDHP** High Deductible Health Plan
Deductible	None	✓	✓
Out-of-Network Care Covered		✓	✓
Referral Needed to see Specialist	✓		
Must select Primary Care Physician	✓		
Pros	• More predictable costs	• You can go anywhere, whether in-network or out-of-network	• A PPO with a high deductible, but with the advantage of a tax-free Health Savings Account
Cons	• Less flexibility • No out-of-network coverage • May have to select Primary Care Physician	• You pay more for out-of-network providers	• More responsibility for out-of-pocket costs until the deductible is met

Click to play video



All About Medical Plans

Medical plans can seem hard to understand, but once you understand the building blocks you will be able to choose the best plan for you and your dependents.

KAISER HMO

You always pay the copayment ($). Kaiser's network is a unique model as the insurance company employs hospitals, doctors, and nurses which members would receive all treatment from, except in an emergency. This "closed" system offers high quality care and benefits at a low-cost relative to other insurance companies.

	KAISER HMO
	In-Network
Plan Year Deductible[1] Individual Family	 None None
Plan Year Out-of-Pocket Maximum Individual Family Embedded/Aggregate[2]	 $ 1,500 $ 3,000 Embedded
Office Visit Primary Care Specialist	 $25 copay $25 copay
Online Visit	No Charge
Preventive Services	No Charge
Chiropractic (up to 30 visits/year)	$20 copay
Lab and X-ray	No Charge
Urgent Care	$25 copay
Emergency Room	$200 copay (waived if admitted)
Inpatient Hospitalization	$100 admission copay
Outpatient Surgery	$25 copay per procedure
PRESCRIPTION DRUGS	
Plan Year Deductible	None
Out-of-Pocket Maximum	Applies to medical out-of-pocket maximum
Retail- 30 Day Supply Generic Preferred Brand Specialty	 $15 copay $30 copay Not Covered
Mail Order- 100 Day Supply Generic Preferred Brand Specialty	 $30 copay $60 copay Not Covered

[1]Deductibles and out-of-pocket maximums accumulate on a plan year from January 1 through December 31.
[2]An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

KAISER RESOURCES

My Health Manager

Stay engaged with your health and simplify your busy life by using the Kaiser Permanente Website.

Kaiser Away From

Kaiser Members are covered for emergency and urgent care anywhere in the world. Whether you're traveling in the United States or a foreign country, Kaiser's travel website will explain what to do if you need emergency or urgent care during your trip.

KP 24/7 Advice

Kaiser's nurse advice is available 24/7 at 833-574-2273. You can speak with a licensed health care professional by phone after regular business hours on health questions, advice about seeking medical care or to let you know what to do if the medical office is closed.

myStrength

myStrength is designed to help navigate life's challenges, make positive changes, and support your overall well-being. The app can help you set goals and work towards them in the ways that work best for you. You can get myStrength at kp.org/selfcareapps and choose the mental health and wellness areas you want to focus on.

Calm

Try the Calm app for self-care and better sleep. Calm is an app that uses meditation and mindfulness to help lower stress, reduce, anxiety, and improve sleep quality. Adult members can get Calm at kp.org/selfcareapps .

ClassPass

Kaiser has teamed up with fitness industry leader ClassPass to make it easier for you to exercise from the comfort of your home or local gym/studio. Kaiser Permanente members can get on demand video workouts at no cost and reduced rates on livestream and in-person fitness classes. To get started, visit kp.org/exercise.

BLUE SHIELD HMOs (ACCESS+ & TRIO)

Access+ HMO plans give members access to more than 44,000 doctors and 370 hospitals.

Trio HMO plans come at a lower premium and are available in 26 counties and gives members access to 17,000 doctors from the Access+ provider network. Trio HMO plans come with valuable bonus features not included with other HMO plans.

You always pay the deductible and copayment ($).

	BLUE SHIELD TRIO	BLUE SHIELD ACCESS+
Plan Year Deductible[1] Individual Family	 None None	 None None
Plan Year Out-of-Pocket Maximum[1] Individual Family Embedded/Aggregate[2]	 $1,000 $2,000 Embedded	 $1,500 $3,000 Embedded
Office Visit Primary Care Specialist	 $15 copay $15 copay ($30 copay if self-referred)	 $15 copay $25 copay ($30 copay if self-referred)
Online Visit	$15	$15
Preventive Services	No Charge	No Charge
Chiropractic (up to 20 visits/year)	$15 copay	$15 copay
Lab and X-ray	No Charge	No Charge
Urgent Care	$15 copay	$15 copay
Emergency Room	$200 copay (waived if admitted)	$200 copay (waived if admitted)
Inpatient Hospitalization	$100 admission copay	$100 admission copay
Outpatient Surgery	No Charge	No Charge
PRESCRIPTION DRUGS (At Participating Pharmacies Only)		
Plan Year Deductible	$100 Individual / $300 Family (applies to brand name only)	$100 Individual / $300 Family (applies to brand name only)
Out-of-Pocket Maximum	$5,600 Individual / $11,200 Family	$6,650 Individual / $13,300 Family
Retail- 30 Day Supply Generic Preferred Brand Non-Preferred	 $10 $30 $50	 $10 $30 $50
Mail Order- 90 Day Supply Generic Preferred Brand Non-Preferred	 $20 $60 $100	 $20 $60 $100

[1]Deductibles and out-of-pocket maximums accumulate on a plan year from January 1 through December 31.
[2]An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

BLUE SHIELD PPO & HDHP

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible, if applicable.

	BLUE SHIELD PPO		BLUE SHIELD HDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Plan Year Deductible[1] Individual Family Embedded/Aggregate[2]	 $750 $1,500 Embedded	 $1,000[4] $2,000[4] Embedded	 $2,000 $6,000 Aggregate	 $4,000[4] $12,000[4] Aggregate
Plan Year Out-of-Pocket Maximum[1] Individual Family Embedded/Aggregate[3]	 $3,750 $7,500 Embedded	 $10,000 $20,000 Embedded	 $5,500 $11,000 Embedded	 $11,000 $33,000 Embedded
Office Visit Primary Care Specialist	 $30 copay $50 copay	 40%[5] 40%[5]	 20%[5] 20%[5]	 50%[5] 50%[5]
Online Visit	$30 (deductible waived)	Not Covered	$40[5]	Not Covered
Preventive Services	No Charge	40%	No Charge	Not Covered
Chiropractic	20%[5] (up to 15 visits per year; acupuncture combined)	40% (up to 15 visits per year; acupuncture combined)	20%[5](up to 26 visits per year; acupuncture combined)	50%[5] (in-network limitations apply)
Lab and X-ray	20%[5,6]	40%	20%[5]	50%[5]
Urgent Care	$30 copay	40%[5]	20%[5]	50%[5]
Emergency Room	20%[5] after $200 copay (waived if admitted)	$200 per visit + 20%[5] (waived if admitted)	20%[5]	20%[5]
Inpatient Hospitalization	20%[5]	40%[5] (max $600 a day)	20%[5]	50%[5] (max $600 a day)
Outpatient Surgery	20%[5]	40%[5] (max $350 a day)	20%[5]	50%[5](max $350 a day)
PRESCRIPTION DRUGS (At Participating Pharmacies only)				
Plan Year Deductible	$100 Individual / $300 Family (applies to brand name only)	Combined with In-Network	Subject to the medical deductible	Subject to the medical deductible
Out-of-Pocket Maximum	$2,850 Individual / $5,700 Family	Out-of-Network claims do not apply to the OOPM	Prescription drugs accumulate towards the medical annual out-of-pocket limit	
Retail- 30 Day Supply Generic Preferred Brand Non-Preferred	 $10 $20 $50	 $10 $20 $50	 20%[5] 20%[5] 20%[5]	 20%[5] 20%[5] 20%[5]
Mail Order- 90 Day Supply Generic Preferred Brand Non-Preferred	 $20 $40 $100	 Not Covered Not Covered Not Covered	 20%[5] 20%[5] 20%[5]	 Not Covered Not Covered Not Covered

[1]Deductibles and out-of-pocket maximums accumulate on a plan year from January 1 through December 31.
[2] An aggregate deductible means your family must meet the entire family deductible before any individual expenses are covered. An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.
[3]An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[4] Combined with in-network
[5] After deductible
[6] X-ray and imaging services in an In-Network Outpatient Radiology Center is $30/visit

CARRUM HEALTH SURGERY BENEFIT
(PPO & HDHP MEMBERS ONLY)

Click to play video

WHERE CAN I GET MORE INFO?

Phone: 888-855-7806

Web: www.carrum.me/EIAHEALTH

Mobile App: Search Carrum Health in the App Story or Google Play to download the app!

A surgery benefit that's hard to believe

When it comes to surgery or major medical treatment, you need to know you're getting the best care. That's why The City of Huntington Beach includes Carrum Health as a benefit to all Blue Shield PPO & HDHP members. Carrum makes it easier, more enjoyable, and less expensive to get high-quality healthcare.

Covered surgeries include:

- Knee
- Hip
- Elbow
- Oncology
- Spine
- Shoulder
- Cardiac (heart)
- Bariatric (weight loss)

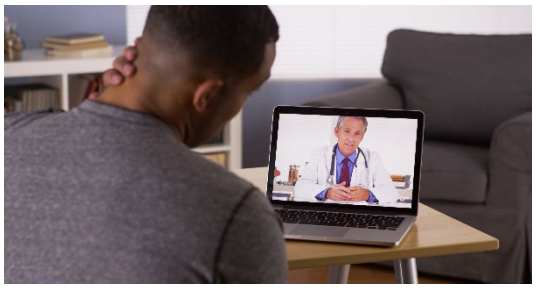
How it works

- **Activate your account**
  Answer a few questions about your health history, read profiles of surgeons, and get a detailed estimate of out-of-pocket costs, if any.
- **Meet your care specialist virtually**
  A dedicated care specialist will reach out to walk you through the process, learn about you and your goals, and answer all of your questions.
- **Relax as Carrum plans your surgery**
  Your care specialist will gather your medical records, submit forms to your surgeon, and plan travel for you and your loved one, if necessary. You'll also meet with your surgeon in person or virtually to ensure surgery is absolutely medically necessary.
- **Receive world-class care**
  You'll be in the best hands on the day of your surgery and walk away feeling stronger and healthier.
- **Never get a medical bill**
  The Carrum Health benefit covers all of the medical costs related to your procedure so you won't have any surprise bills.

WHEN YOU NEED CARE NOW

(BLUE SHIELD MEMBERS ONLY)

Teladoc HEALTH



GET THE CARE YOU NEED

Teladoc Health doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Sinus problems
- Urinary tract infection
- Respiratory infection
- Skin problems
- And more!

Talk to a doctor anytime

Teladoc Health gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone, video or mobile app visits. It's an affordable alternative to costly urgent care and ER visits when you need care now.

Meet our doctors

Teladoc Health is simply a new way to access qualified doctors.

All Teladoc Health doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 20 years' experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

When should you use Teladoc Health?

Teladoc Health does not replace your primary physician. It is a convenient and affordable option for quality care.

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

Teladoc Health is just a call or click away!

Teladoc.com | 800-Teladoc

Available on the iPhone App Store

ANDROID APP ON Google play

BLUE SHIELD RESOURCES

Our medical coverage provides our Blue Shield members with a variety of helpful health and wellness resources at no cost. As a Blue Shield member, we encourage you and your eligible family members to register at **blueshieldca.com** to access tools to help you improve your health, make informed decisions about your care, and find options to save you money.

SHIELD CONCIERGE (TRIO HMO PLAN ONLY)

One of the most powerful features of our Trio HMO plan is Shield Concierge. Shield Concierge is a team of registered nurses, health coaches, social workers, pharmacists, pharmacy technicians, and dedicated customer service representatives, who all work together for you. They are ready to help provide personalized support on all aspects of your care, including benefits, claims, providers, care coordination, case management, health coaching, and pharmacy, plus more. If you are a Trio member, call (855) 829-3566 to speak to the Shield Concierge team.

Bluecard – Stay covered while traveling

When you're outside of California or out of the country, you and your family can get urgent and emergency care through the BlueCard® and Blue Shield Global Core programs. These programs offer access to doctors and hospitals almost everywhere in the U.S. and in 170 countries and territories around the world.

To find a provider in the U.S. visit provider.bcbs.com or call (800) 609-4166 . To find a provider outside the U.S. visit bcbsglobalcore.com or call (800) 810- BLUE (2583) collect from outside the U.S.

Away From Home (HMO Plans Only)

Blue Shield HMO members and their covered dependents qualify for Away From Home Care if they meet one of the following circumstances and will be on an extended stay: long-term traveler, families living apart, student.

Blue Plans participating in the Away From Home Care program will honor temporary enrollment in their HMOs, so you can consider Blue plan physicians in other cities as your extended healthcare network. Note: Away From Home Care is not available in all states. For more information, please call (800) 622-9402 .

Virtual Or Walk-in Health Care at CVS and Target (PPO Members Only)

You can get virtual and in-person non-emergency health care at CVS and Target Clinics across California through MinuteClinic. Staffed by board-certified nurse practitioners, CVS and Target offer affordable access to care seven days a week, including evenings and weekends. You may need an appointment for a virtual visit. You can find hours of operation and a list of services at cvs.com/minuteclinic and target.com/clinic.

Safeguard your identity and your credit

Protecting your financial well-being is as important as protecting your health. Eligible Blue Shield medical plan members are offered identity protection services that include credit monitoring, identity repair assistance, and identity theft insurance. To learn more, visit experianidworks.com/blueshieldca. When creating your account, you will need to provide the activation code BCBSCALI23. For assistance, call (877) 890-9332 .

BLUE SHIELD WELLNESS

LEARN ABOUT PREVENTIVE CARE FOR YOU AND YOUR FAMILY

Seeing your doctor once a year for a preventive care visit can help you catch small problems before they turn into big ones. Find out what screenings, services, and immunizations we recommend for you and your family. Visit blueshieldca.com/preventive.

GET YOUR FLU SHOT AND MORE AT A RETAIL PHARMACY

Blue Shield's large network of retail pharmacies offers several preventive vaccines, including the annual flu shot, at no extra charge without a prescription. You can still get vaccines at your doctor's office, instead of a pharmacy, if you prefer. For more information, go to blueshieldca.com/pharmacy. Or call the customer service number on your Blue Shield member ID card.

Make real improvements to your health with Wellvolution

Wellvolution is a digital platform for health and well-being. It offers over 50 tested apps and programs to help you achieve your health goals – at no extra cost. Areas of focus include disease prevention and reversal, nutrition, sleep, stress, smoking and more! Learn more at wellvolution.com.

Save on fitness club memberships & more

Get help saving money and living healthier with a wide range of wellness discount programs, including Fitness Your Way™. This program gives you access to more than 800 fitness centers in California and more than 10,000 nationwide for just $25 per month. The wellness discount programs also include acupuncture and chiropractic services; therapeutic massage; and eye exams, frames, contact lenses, and LASIK surgery. Learn more at blueshieldca.com/wellnessdiscounts.

Care Management Program

Get support managing your health needs for conditions such as diabetes, depression, chronic pain, cancer, as well as other conditions. Services include personalized health coaching, care plan development, provider coordination, plus more. To learn more, go to blueshieldca.com/wellness and click on Conditions and care programs, and then select Shield Support. You can also call (877) 455-6777 to find out if you're eligible.

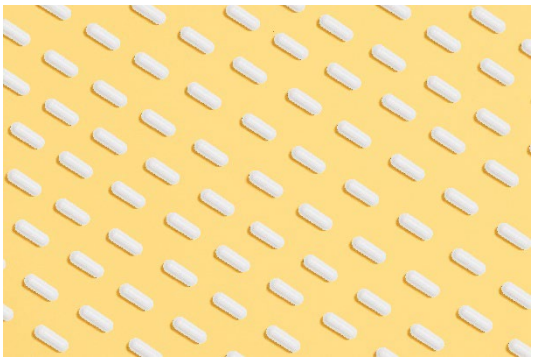
Maternity Program

Expecting a bundle of joy? We want you and your baby to be healthy. Blue Shield's Maternity Program offers assistance including a consultation with a registered dietitian, assessments at pregnancy milestones, and access to a 24/7 support hotline staffed by experienced nurses. To learn more, go to blueshieldca.com/wellness, click on Conditions and care programs, and then select the Maternity Program.

Lifereferrals℠ – Get expert support in meeting life's challenges

Call LifeReferrals℠ 24/7℠ anytime and talk with experienced professionals ready to help you with personal, family, and work issues. Get referrals for three face-to-face or telephone visits in a six-month period with a licensed counselor. Legal and financial consultations are also available. For more information, visit your Blue Shield Member portal to access Lifereferrals℠.

PRESCRIPTION DRUGS – KAISER & BLUE SHIELD



Below is some information to keep in mind regarding this coverage:

Kaiser HMO

Save money by purchasing your prescriptions through the mail order program. Receive a 100-day supply of your prescribed medication for the cost of a 90-day supply. To get started with the mail order program, call KAISER at (866) 206-2983. You can also get more information through your KP.org portal.

Blue Shield HMOs & PPO

Council members who are enrolled in the Blue Shield HMO, Trio and PPO plans will have prescription drug coverage through Express Scripts.

Save money by purchasing your prescriptions through the mail order program. Receive a 90-day supply of your prescribed medication for the cost of a 60-day supply. To get started with the mail order program, call Express Scripts at (800) 711-0917.

Blue Shield HDHP

Council members who are enrolled in the Blue Shield HDHP plan will have prescription drug coverage through Blue Shield.

Save money by purchasing your prescriptions through the mail order program. Receive a 90-day supply of your prescribed medication for the cost of a 60-day supply. To get started with the mail order program, call Blue Shield at (866) 346-7200.

Prior Authorization/ Step Therapy/Quantity Limits

To ensure safe and appropriate use of medications, prior authorization, step therapy, and/or quantity limits may apply for certain medications. For definitions on what each of these mean, please refer to the Glossary section.

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Preferred
$$$	Non-Preferred

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

HEALTH SAVINGS ACCOUNT (HSA) (HDHP ONLY)

Click to play video

ARE YOU ELIGIBLE?

The HSA is not for everyone. You're eligible only if you are:

1. Enrolled in the **BLUE SHIELD HDHP**
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.
4. Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future.

How the Blue Shield HSA works

- If you enroll in the Blue Shield HDHP plan, an HSA packet will be sent to your mailing address, you will need to activate your account using the information provided in the HSA packet.
- You can contribute up to the 2023 annual limit set by the IRS:
  Individual: $3,850
  Family: $7,750
  Are you age 55 **or over?** You can contribute an additional $1,000 per year
- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but no penalties.

Find out more

- Eligible Expenses
- Ineligible Expenses
- The Easy Guide to Understanding Your HSA

DENTAL

OUR PLANS

DELTA DENTAL PPO

DELTA DENTAL HMO

DID YOU KNOW?

Keeping your teeth and gums healthy isn't the only reason you should practice preventive dental care. With good dental hygiene, you can greatly reduce your risk of getting cavities, gingivitis, periodontitis, and other dental problems.

You can also reduce your risk of secondary problems caused by poor oral health such as diabetes, heart disease, osteoporosis, respiratory disease and even cancer.

Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

DELTA DENTAL (DPPO & DHMO)

You always pay the deductible and copayment ($). The coinsurance (%) shows what you pay after the deductible.

	DELTA DENTAL DPPO		DELTA DENTAL DHMO
	In-Network	Out-of-Network	In-Network
Annual Deductible Individual Family (combined with in-network)	$25 $75	$25 $75	$0 $0
Annual Plan Maximum	$2,000 per person	$2,000 (combined with in-network)	Unlimited
Waiting Period	None	None	N/A
Diagnostic & Preventive	15%; deductible waived	15% [1]	Plan Pays 100% [2]
Basic Services Fillings Root Canals Periodontics	15% [1]	15% [1]	Plan pays 100% [2]
Major Services	Prosthodontics: 40% [1] All other: 15% [1]	Prosthodontics: 40% [1] All other: 15% [1]	Plan covers most services at 100% [2]
Orthodontia Adults Dependent Children	40% Covered	40% Covered	$500 + start up for normal 24-month treatment [2]
Ortho Lifetime Max	$3,000	$3,000 (combined with in-network)	Unlimited

[1] After deductible
[2] See contract for fee schedule

What you need to know about your DPPO plan

Features:	See any provider, but you'll pay more out of network.
Am I restricted to in-network providers?	No
Do I have to select a primary dentist?	No
Can I use my HSA or FSA?	If you participate in a healthcare HSA or FSA, you can use your account to pay for dental expenses.

VISION

OUR PLAN

Vision Service Plan (VSP)

Click to play video

Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

VISION SERVICE PLAN (VSP)

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	PLAN NAME	
	In-Network	Out-of-Network
Exams		
Benefit	$15 copay	$50 copay
Frequency	Once every 12 months	Once every 12 months
Materials	100% after $15 copay (combined with exam)	See schedule below
Eyeglass Lenses		
Single Vision Lens	Combined with exam	Up to $50
Bifocal Lens	Combined with exam	Up to $75
Trifocal Lens	Combined with exam	Up to $100
Frequency	Once every 12 months	Once every 12 months
Frames		
Benefit	Up to $150 allowance Up to $170 allowable for featured brands Costco: Up to $80 allowance	Up to $70 allowance
Frequency	Once every 12 months	Once every 12 months
Contacts (Elective)		
Benefit	Up to $150 allowance (in lieu of eyeglasses)	Up to $105 allowance (in lieu of eyeglasses)
Frequency	Once every 12 months	Once every 12 months

What you need to know about this plan

Features: See any provider, but you'll pay more out of network.

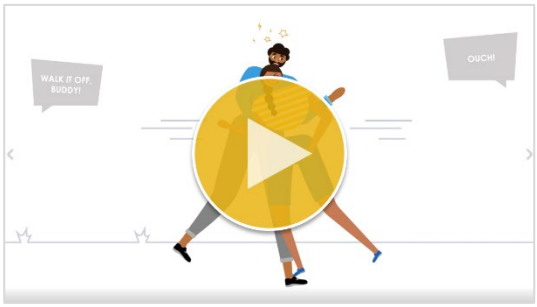
What other services are covered? The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and even hearing aids.

Eyeglasses are expensive. Will I still be able to afford them, even with insurance? Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in an HSA or healthcare FSA, you can use your account to pay for vision care and eyewear with tax-free dollars.

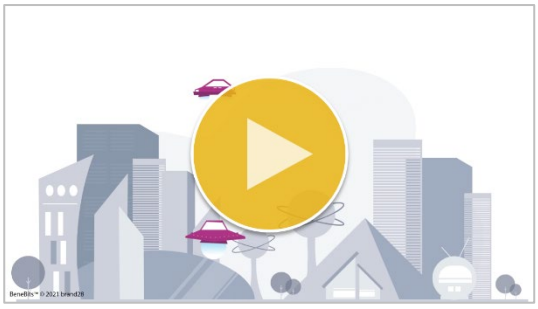
Where can I get more details? Use the VSP website or app.

ENGAGE

Click to play video



Urgent Care vs ER



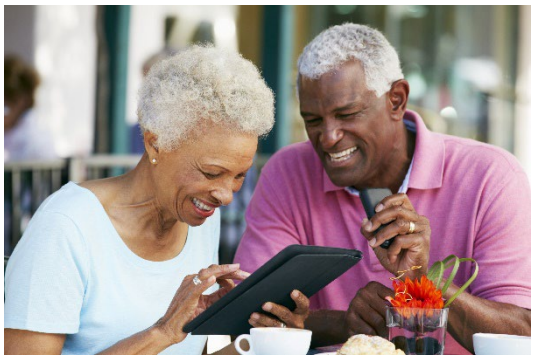
Virtual Healthcare

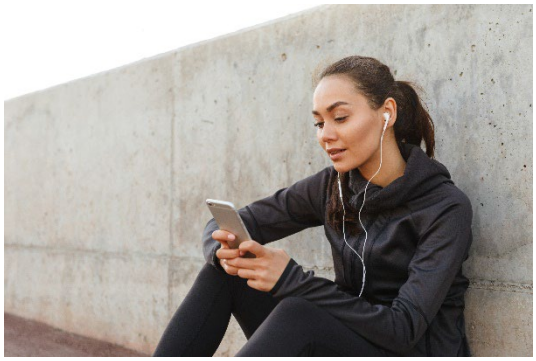
Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs

MOBILE & WEB RESOURCES





Access your benefits anytime, anywhere

Most of our carriers and vendors have mobile apps available making accessing your benefits information easier than ever.

Just download the apps via the Apple App Store and Google Play and make sure to share with your dependents!

Blue Shield Plan Members

View your ID card, search for doctors, track your claim information, understand your benefits, and more. The Blue Shield of California app provides BSC members enhanced 24/7 service and ease-of-access to the information that matters most.

To locate a Blue Shield provider near you please visit the BlueShield.com

Kaiser Plan Members

As a Kaiser Permanente member, the Kaiser mobile app is your connection to great health and great care. Once you register, you'll have easy access to time-saving tools and resources that help you stay on top of your health and feeling great.

To locate a Kaiser provider near you, please visit KP.org

Delta Dental Plan Members

Your oral health is important to Delta Dental — and to your overall health! We've designed our mobile app to make it easy for you to make the most of your dental benefits. Maximize your health, wherever you are! Search for a dentist near you, view ID cards, and more, right on your mobile device.

To find a dentist near you please visit DeltaDental.com

VSP Plan Members

Manage your eye care needs at any time, and from anywhere, with the VSP Vision Care App. View your benefits coverage, access your member ID card, find doctor, get exclusive member exclusive extras, shop eyewear and contacts.

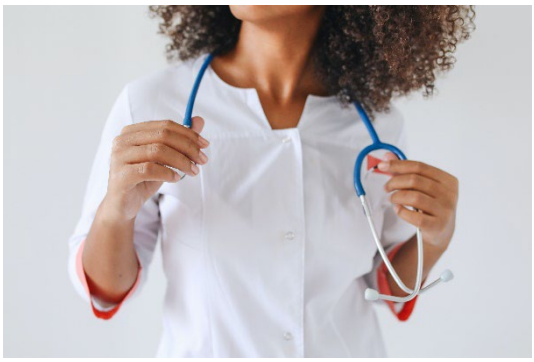
To locate a VSP provider near you please visit VSP.com

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Online visit	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	**$**
Office visit	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	**$$$$$**

PREVENTIVE CARE SCREENING BENEFITS



TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit cdc.gov/prevention for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

LIFE AND AD&D

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Consider what your family would need to cover day-to-day living expenses and medical bills, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide a base amount of life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children.

LIFE AND AD&D INSURANCE

A NOTE ABOUT TAXES

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

EVIDENCE OF INSURABILITY (EOI)

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

Company Paid Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by The Standard and premiums are paid in full by The City of Huntington Beach.

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

Voluntary Life Insurance

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by The Standard and available for your spouse and/or child(ren).

Council Member	Increments of $10,000 up to $500,000
Spouse	Increments of $10,000 up to $500,000, not to exceed 100% of council member Voluntary Life amount.
Child(ren)	Increments of $2,500 up to $10,000

Voluntary AD&D Insurance

Voluntary AD&D Insurance allows you to purchase accidental death and dismemberment coverage that pays your beneficiary if you have a fatal accident. If you experience a serious injury such as a loss of a limb, speech, sight or hearing, the plan pays a benefit to you.

Coverage is provided by The Standard and is available for your spouse and/or child(ren).

Council Member	$25,000, $50,000, $75,000 or $100,000
Family	Coverage available for spouses and dependent children, as a percentage of the council member’s principal amount

VOLUNTARY LIFE & AD&D INSURANCE COSTS

If you elect voluntary coverage, your monthly premium rate is calculated based on your age and the amount of coverage.

VOLUNTARY LIFE INSURANCE –
MONTHLY RATE PER $1,000 OF COVERAGE

AGE	EMPLOYEE/SPOUSE
Under age 24	$0.081
Age 25-29	$0.081
Age 30-34	$0.081
Age 35-39	$0.113
Age 40-44	$0.187
Age 45-49	$0.317
Age 50-54	$0.519
Age 55-59	$0.894
Age 60-64	$1.075
Age 65-69	$1.604
Age 70-74	$3.025
Age 75 +	$3.025

To view your complete rate sheet and cost please click here

VOLUNTARY AD&D
MONTHLY RATE PER $1,000 OF COVERAGE

Employee	$0.040
Employee + Family	$0.058

To view your complete rate sheet and cost please click here

CHILD LIFE INSURANCE

COVERAGE AMOUNT	RATE	TOTAL COST PER PAYCHECK
$2,500	$0.420	$0.19
$5,000	$0.840	$0.39
$7,500	$1.260	$0.58
$10,000	$1.680	$0.78

Premium includes all eligible children. Eligible children include dependent children under age 26 if you apply for and are approved for coverage for yourself.

WELLBEING & BALANCE

THE KEY TO KEEPING YOUR BALANCE IS KNOWING WHEN YOU'VE LOST IT

The challenges of daily life can be hard to balance. Whether it's work, school or family obligations, it's no wonder that many of us sometimes have trouble managing the ups and downs of our day-to-day lives.

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, chemical dependency, mental health and family issues
- Maximize your physical well-being
- Take time to spend with family and friends, take care of personal business, or just have a little extra "me time"

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

MENTAL HEALTH RESOURCES

These are challenging times, and we understand that you or people close to you may also be faced with additional work and family stresses. Feelings of isolation, depression or despair should never be taken lightly. This is a reminder that our medical plans include coverage for mental health care. And through our telemedicine provider, you can connect to a mental health provider within minutes, from any location, at any time.

	In-Network Mental Health Services	
	Outpatient	Inpatient
Blue Shield Access+ HMO	$15/visit	$0
Blue Shield HDHP	$20[1]	20%[1]
Blue Shield Trio HMO	$15/visit	$0
Blue Shield PPO	$30/visit	20%[1]
Kaiser HMO	Individual: $25 per visit Group: $12 per visit[2]	$100 per admission

[1]After deductible
[2]Group mental health treatment

IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms

PLAN CONTACTS

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

Plan Type	Provider	Phone Number	Website	Group #
Medical	Kaiser	(800) 464-4000	www.kp.org	227450
	Blue Shield	(855) 256-9404	www.blueshieldca.com	W0052144
Prescription (Blue Shield HMO's & PPO)	Express Scripts	(877) 554-3091	www.express-scripts.com	Rx BIN: 610014 Rx Group: RX4EIAH
TeleHealth	Teladoc	(800) 835-2362	www.teladoc.com	N/A
NurseHelp 24/7℠	Blue Shield	(877) 304-0504	www.blueshieldca.com	N/A
Surgery Concierge	Carrum	(888) 855-7806	www.carrum.me/EIAHEALTH	N/A
Dental	Delta Dental PPO	(800) 765-6003	www.deltadentalins.com	04729
	Delta Dental HMO	(800) 422-4234	www.deltadentalins.com	71575
Vision	VSP	(800) 877-7195	www.vsp.com	00105162
HSA Bank	Optum	(866) 234-8913	www.optumbank.com	N/A
Life	The Standard	(888) 937-4783	www.standard.com	759645
Retirement	CalPERS	(888) 225-7377 (888) CAL-PERS	www.calpers.ca.gov	4840650877
	PARS Retirement	(800) 540-6369	www.parsinfo.org	N/A
Benefits	Human Resources	(714) 375-8456	SurfNet	N/A

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

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

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more, or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

DEADLINE FOR FILING LAWSUIT UNDER ERISA AFTER EXHAUSTION OF ALL CLAIMS PROCEDURES

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan specific statute of limitations.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.61% in 2022 of your modified adjusted household income.

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to The City of Huntington Beach Health & Welfare Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Medicare Part D Notice

Important Notice from The City of Huntington Beach About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The City of Huntington Beach and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Huntington Beach has determined that the prescription drug coverage offered by the all of our medical plan options is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your The City of Huntington Beach coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.
Important Note for Retiree Plans: Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

Since the existing prescription drug coverage under all of our plan options, are creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your City of Huntington Beach prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with The City of Huntington Beach and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The City of Huntington Beach changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	01/01/2023
Name of Entity/Sender:	The City of Huntington Beach
Contact-Position/Office:	Human Resources
Address:	2000 Main Street, Huntington Beach, CA 92648
Phone Number:	(714) 375-8456

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in The City of Huntington Beach health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in The City of Huntington 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 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 The City of Huntington Beach health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

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

Notice of Choice of Providers

HMO plans generally requires 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**.** For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your carrier directly.

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

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

Availability of Privacy Practices Notice

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

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're 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 aren't eligible for Medicaid or CHIP, you won't 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 aren't 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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – 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
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, press 2
INDIANA – Medicaid
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: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx | Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP | Phone: 1-800-694-3084
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm | Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
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

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Websi Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2022, 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.

OMB Control Number 1210-0137 (expires 1/31/2023)