



RETIREE BENEFITS GUIDE

July 1, 2012 through June 30, 2013

Prepared by: Human Resources

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Disclaimer: Please note that this document is not intended to be a legal benefit plan document or an agreement of employment. CITY OF VICTORVILLE reserves the right to change or terminate benefit plans at its discretion.

Introduction

City of Victorville takes pride in offering a benefit program which provides flexibility for the diverse and changing needs of our employees. **City of Victorville** offers a choice of two medical plans, two dental plans, as well as other insurance coverage that make up a very comprehensive benefits package for the retirees of the City.

Our Early Retirees (under age 65) have an option of enrolling in either Health Net or Kaiser's HMO medical plan. Retirees age 65 and over must be enrolled with Medicare Part A (Hospital) and Part B (Medical) in order to be eligible for a medical plan through the City. Then, you have a choice of The Hartford's Medicare Supplemental Plan that includes a pharmacy benefit through Express Scripts, Inc. or Kaiser's Senior Advantage 65+ HMO program that also includes a prescription drug benefit.

Please note that Medicare eligible retirees enrolled with The Hartford, the plan's rates renew each calendar year effective January 1st.

City of Victorville's open enrollment period is annually from May 1st through May 30th with benefit selections effective July 1st. Once coverage is selected, changes can only be made annually during the annual open enrollment period (the month of May). Adding coverage for the employee and/or dependents during the plan year may be allowed, depending on the reason for the employee's and/or dependent's loss of prior coverage. Please contact Human Resources if you have any questions. Our City's Human Resources staff is: Diana Ramirez, Josie Trevino, Tom Jordan, Sandra Heredia and Candace Harper-Woods.

Helpful Information

PLAN	INSURANCE CARRIER	GROUP NUMBER	MEMBER SERVICES	WEBSITE
MEDICAL HMO	Kaiser Permanente	224606	1-800-464-4000	www.kaiserpermanente.org/california City of Victorville microsite: http://my.kp.org/ca/cityofvictorville
	Health Net	57739	1-800-522-0088	www.healthnet.com
RETIREE HEALTH PLAN	Kaiser Senior Advantage 65+	224606	1-800-464-4000	www.kaiserpermanente.org/california City of Victorville microsite: http://my.kp.org/ca/cityofvictorville
	The Hartford (Administered by TAGCO)	AGP3138	1-800-368-3653 Retiree Claim	www.umar.com
RETIREE PRESCRIPTION DRUG PLAN	Express Scripts Ins., Company (Available with The Hartford)	#15	1-888-345-2560	www.express-scripts.com/pa
DENTAL DHMO	Assurant-UDC	5458591	1-800-443-2995	www.assurantemployeebenefits.com
DENTAL PPO	Assurant	5458591	1-800-442-7742	www.assurantemployeebenefits.com
VISION	MES Vision through Blue Shield of CA	F21708	1-877-601-9083	www.mesvision.com
HUMAN RESOURCES	1-760-955-5051 HR@ci.victorville.ca.us			www.ci.victorville.ca.us
BROKER	Alliant Insurance Services, Inc. 701 B Street, 6th Floor San Diego, CA 92101 Debra K. Harrold, Account Executive 619- 849-3778			www.AlliantInsurance.com

Health Insurance Eligibility

Eligibility *City of Victorville* defines “Full-Time Benefit Eligible” employees who are regularly scheduled for 36 hours a week and in a Full-Time classification designated in the Table of Organization-Benefit Resolution. Full-Time employees are eligible for *City of Victorville* group benefits on the 1st of the month following one month of active employment.

What happens if I Waive Health Insurance Coverage? If an eligible employee waives coverage in any of the medical, dental and vision benefits being offered, they will be forfeiting their eligibility, and will not be able to enroll until the next open enrollment period without a qualifying “life event” (see below).

Dependent Eligibility As of July 1, 2012 the definition of dependent includes: spouse or domestic partner (as defined by California law) and unmarried/married child(ren) up to 26 years of age. Unmarried/married child(ren) includes the child(ren) placed under a “qualified medical child support order,” or adopted child(ren) and student status is not required. This adult dependent extension does not apply to dependents that are eligible for coverage through their own employer sponsored group health, dental and/or vision plans.

If the covered dependent reaches the plan age limit, please notify Human Resources immediately for COBRA information. They will be eligible to continue coverage at the single party rate plus 2% COBRA fee for up to 36 months.

Cost of Coverage As an eligible employee, *City of Victorville* pays a majority of the cost of the health coverage for full-time benefit eligible employees.

How to Waive Coverage If an eligible employee chooses not to participate in the medical, dental, vision or any other benefit offerings, please initial the opt out box on the Flexible Benefit Plan Election form.

When is a Dependent eligible? Dependents are eligible on the employee’s eligibility date, the date the dependent is added, or the date of the “life event.”

Adding Dependents New dependents may be added to the health insurance plans during the year by completing the necessary forms within **30 days** of their becoming eligible. If they are not added within the **30 day period** and have not had a “life event” (see below), the employee will have to wait until the next annual open enrollment period to add the dependent.

Life Event In order to change coverage elections under the health insurance plan outside the annual open enrollment period, the employee must have experienced a qualified “Life Event.” Examples of Life Events are described as follows:

- Marriage, legal separation, or divorce
- Birth or adoption of a child
- An over age dependent is no longer eligible
- Retirement or termination of employment
- Death of a spouse or child
- Change in your or your spouse’s employment status (such as losing a job, becoming employed, reduction in hours)



When Am I Eligible to Enroll?

The following chart describes the benefit programs available to you as a benefit eligible employee. Your eligibility date to enroll is the first of the month following one month of active employment. You can make changes to your benefits during open enrollment or within 30 days of a change in status.

Medical Insurance When Turning 65

- When you are within six months of reaching age 65, you may contact the local Social Security office to apply for Part A and B of Medicare. You must contact Human Resources directly prior to your 65th birthday to enroll in a Medicare retiree plan offered from the City.
- Your Medicare card will need to be provided to Human Resources.
- New enrollment forms will need to be completed and mailed to Human Resources to enroll in one of the Medicare medical plans.

You Are Medicare Eligible And Your Spouse Is Not, Or Vice Versa

Both you and your spouse will be required to complete the applicable enrollment form for the plans for which you are eligible.

- For example: If you, as the retiree, are not eligible for Medicare (example: Under age 65), and you are currently on the Kaiser Permanente plan with City of Victorville, no action is needed from you. If your spouse is eligible for Medicare, then the spouse needs to complete the Group Kaiser Senior Advantage election form. If you are retired, and already enrolled with Kaiser, you will need to complete the Senior Advantage Group Election Form if you are Medicare eligible. If your eligible dependent spouse is Medicare eligible, they need to complete the Senior Advantage Election Form too.

BENEFITS PROGRAM	You Only	You, Your Spouse & Dependents	Employee Coverage is Effective on First of the Month Following 1 Month	Within 30 days of a Change in Status
MEDICAL - Early Retirees Under Age 65				
Kaiser Permanente HMO Medical	X	X	X	X
Health Net HMO Medical	X	X	X	X
MEDICAL - Retirees Age 65 and Over				
Kaiser Permanente Senior Advantage Plan*		X (You & Your Spouse, No Dependents)		
The Hartford (Administered by TAGCO)* Retiree Health Plan		X (You & Your Spouse, No Dependents)		
Express Scripts Retiree Prescription Drug Plan with The Hartford plan		X (You & Your Spouse, No Dependents)		
DENTAL & VISION - All Retirees				
Assurant-UDC Dental DHMO Plan	X	X	X	X
Assurant Dental PPO	X	X	X	X
MES Vision through Blue Shield of California	X	X	X	X

*Retiree is effective 1st of the month in which they turn 65.

What is a Change in Status?

Certain life events provide the opportunity for you to make changes to your benefits. If you experience one of these events, you must contact **City of Victorville's** Human Resources **within 30 days** of the date of the qualifying change in status to modify your benefits.

The following events qualify as a Change in Status:

You:

- Get married, divorced, legally separated or have your marriage annulled; or
- Give birth to a child, adopt a child or a child is placed in your home in anticipation of adoption.

An Eligible Dependent:

- Satisfies or ceases to satisfy eligibility requirements;
- Is covered under another employer's plan and makes an election change during that employer's enrollment period; or
- Is covered under another employer's plan and that employer alters that plan by: changing benefit plan options; changing coverage within an existing plan or significantly altering the cost of the plan;
- Dies.

You or an Eligible Dependent:

- Have a change in employment status, including a change in work schedules, a switch between part and full-time, beginning or returning from a leave of absence;
- Becomes eligible for Medicare or Medicaid; or,
- Lose Credible Coverage under another plan (spouse's coverage, State sponsored plan, etc.)



Benefit Highlights

Kaiser Permanente Medical HMO (California Only)

Plan Information

224606 City Of Victorville

Principal Benefits for Kaiser Permanente Traditional Plan (7/1/12—6/30/13)

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Southern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage (EOC)* for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Call Center.

Annual Out-of-Pocket Maximum for Certain Services

For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member)	\$1,500 per calendar year
For any one Member in a Family of two or more Members	\$1,500 per calendar year
For an entire Family of two or more Members	\$3,000 per calendar year

Deductible or Lifetime Maximum None

Professional Services (Plan Provider office visits)

You Pay

Most primary and specialty care consultations, exams, and treatment	\$15 per visit
Routine physical maintenance exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling	No charge
Scheduled prenatal care exams and first postpartum follow-up consultation and exam...	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Urgent care consultations, exams, and treatment	\$15 per visit
Physical, occupational, and speech therapy	\$15 per visit

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures	\$15 per procedure
Allergy injections (including allergy serum)	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Health education:	
Covered individual health education counseling	No charge
Covered health education programs	No charge

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs

No charge

Emergency Health Coverage

You Pay

Emergency Department visits

\$35 per visit

Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).

Ambulance Services

You Pay

Ambulance Services

No charge

Prescription Drug Coverage

You Pay

Covered outpatient items in accord with our drug formulary guidelines at Plan Pharmacies or through our mail-order service:

Most generic items	\$10 for up to a 100-day supply
Most brand-name items	\$20 for up to a 100-day supply

Benefit Highlights

Kaiser Permanente Medical HMO (California Only)

Plan Information (continued)

Durable Medical Equipment	You Pay
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines.....	No charge
Mental Health Services	You Pay
Inpatient psychiatric hospitalization.....	No charge
Individual outpatient mental health evaluation and treatment.....	\$15 per visit
Group outpatient mental health treatment.....	\$7 per visit
Chemical Dependency Services	You Pay
Inpatient detoxification.....	No charge
Individual outpatient chemical dependency evaluation and treatment.....	\$15 per visit
Group outpatient chemical dependency treatment.....	\$5 per visit
Home Health Services	You Pay
Home health care (up to 100 visits per calendar year).....	No charge
Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period).....	No charge
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies.....	No charge
All Services related to covered infertility treatment.....	50% Coinsurance
Hospice care.....	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC. Please note that we provide all benefits required by law (for example, diabetes testing supplies).



Benefit Highlights

Health Net HMO Medical (California Only) Plan Information

PLAN DISCLAIMER

This Schedule of Benefits is a brief list of benefits, with applicable copayments, coinsurance and deductibles information for your health plan. It does not list the exclusions and limitations or other important terms applicable to your plan.

The Evidence of Coverage (EOC) for your plan contains the complete terms and conditions of your Health Net coverage. It is important for you to thoroughly review the EOC for your plan.

Health Net HMO Plan Chart (GF) Plan 2LG	2LG 10/1/2010
PROFESSIONAL SERVICES	
Visit to a physician, physician assistant or nurse practitioner at a PPG.	\$15
Periodic health evaluations. Includes annual preventive physical examinations, routine, preventive care, and well-baby care.	\$15
Vision and hearing examinations.	\$15
Specialist consultations. Includes OB/GYN self-referral. Refer to the Introduction pages for additional information.	\$15
Physician visit to member's home (at discretion of physician).	\$30
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders).	\$0
Other immunizations (except foreign travel/occupational - see below).	\$0
Immunizations for foreign travel/occupational purposes.	20%
Allergy testing.	\$0
Allergy serum.	\$0
Allergy injection services (serum not included).	\$0
Injections related to infertility services.	50%
All other injections.	\$0
Surgeon/assistant surgeon in hospital or PPG.	\$0
Administration of anesthetics.	\$0
X-ray and laboratory procedures.	\$0
Rehabilitation therapy (outpatient physical, speech, occupational and respiratory therapy). Provided as long as significant improvement is expected. See <i>PPG Operations Manual</i> .	\$0
Dental services (when medically necessary to properly monitor, control or treat a severe medical condition when excluded dental services are being performed. See <i>PPG Operations Manual</i>).	\$0
CARE FOR CONDITIONS OF PREGNANCY (professional services only)	
Prenatal and postnatal office visit.	\$15
Normal delivery. Cesarean section. Includes newborn inpatient care provided by a member physician.	\$0
Complications of pregnancy, including medically necessary abortions.	\$0
Elective abortions.	\$150
Genetic testing of fetus.	\$0
Circumcision of newborn.	\$0
FAMILY PLANNING (professional services only)	
Contraceptive devices.	Not covered
Infertility services (including professional services, inpatient and outpatient care, treatment by injection and prescription drugs, if applicable. See <i>PPG Operations Manual</i>).	50%
Sterilization of females.	\$150
Sterilization of males.	\$50
Reversal of sterilization.	Not covered

ALCOHOL/DRUG REHABILITATION and CARE FOR MENTAL DISORDERS

ADMINISTERED BY MANAGED HEALTH NETWORK (MHN)

Refer members to the MHN telephone number on the back of their Health Net ID card

Benefit Highlights

Health Net HMO Medical (California Only) Plan Information (continued)

Health Net HMO Plan Chart (GF) Plan 2LG	2LG
OTHER SERVICES	
Medical social services.	\$0
Patient education.	\$0
Ground ambulance.	\$0
Air ambulance.	\$0
Durable medical equipment.	\$0
Orthotics (braces and supports).	\$0
Corrective footwear. Custom made shoes and shoe inserts (custom foot orthotics).	Not covered
Diabetic supplies (refer to the Introduction section for additional information).	\$0
Hearing aids.	Not covered
Prosthesis (replacing body parts).	\$0
Blood and blood products.	\$0
Nuclear medicine (professional services only).	\$0
Organ and bone marrow transplants (non-experimental and noninvestigative. Professional services only).	\$0
Chemotherapy or radiation therapy (professional services only).	\$0
Renal dialysis (professional services only).	\$0
Home health visit. The copayment starts the 31st calendar day after the first visit.	\$15
Hospice care.	\$0
HOSPITAL AND SKILLED NURSING FACILITY SERVICES	
Unlimited days of hospital care in a semi-private room or ICU with ancillary services. Excluding care for mental disorders.	\$0
Confinement in a skilled nursing facility (limited to 100 days a calendar year).	\$0
Maternity care. Includes routine nursery charges.	\$0
Outpatient services.	\$0
OUT-OF-POCKET MAXIMUM	
For each member.	\$1,500
For two-party.	\$3,000
For each family (3 or more members).	\$4,500
EMERGENCY CARE/URGENTLY NEEDED CARE - Within or outside the PPG service area - (Refer to the Introduction pages for more information)	
NOTE: Non-emergency care (including urgently needed care) received within the PPG service area must be performed or authorized by the member's PPG in order for services to be covered. When urgently needed care is provided outside the PPG service area, authorization is not mandatory in order for services to be covered. When services are provided that meet the criteria for emergency care, whether within or outside the PPG service area, the services are covered, even if the member never contacted the PPG. See the Introduction pages for more information.	
Use of emergency room (facility and professional services). *	\$35
Use of urgent care center (facility and professional services). *	\$35

* The copayment will not be required if the member is admitted as a hospital inpatient directly from the emergency room or urgent care center. See the Introduction pages for more information regarding emergency services/urgently needed care.



Standard Behavioral *Plan 652*

<i>Benefit description</i>	<i>Member responsibility</i>
Mental health	
Severe mental illness	
<i>Outpatient</i>	
Outpatient copayment	\$15
Maximum visits per calendar year	Unlimited
<i>Inpatient</i>	
Inpatient care for mental health in hospital or skilled nursing facility	No charge
Maximum days per calendar year	Unlimited
Other mental illness	
<i>Outpatient</i>	
Outpatient copayment	\$15
Maximum visits per calendar year	Unlimited
<i>Inpatient</i>	
Inpatient care for mental health in hospital or skilled nursing facility	No charge
Maximum days per calendar year	Unlimited
Chemical dependency rehabilitation	
<i>Outpatient</i>	
Individual therapy session	\$15
Group therapy session	\$7.50
Maximum visits per calendar year	Unlimited
<i>Detoxification</i>	
<i>Inpatient</i>	
Chemical dependency rehabilitation	No charge
Maximum days per calendar year	Unlimited



This is a summary of benefits. It does not include all services, limitations or exclusions. Please refer to the Evidence of Coverage for terms and conditions of coverage.

The following conditions are considered severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorders, obsessive compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa, and serious emotional disturbances of children (SED).

HEALTH NET HMO PHARMACY BENEFITS

DRUG TYPE	DESCRIPTION	COPAYMENT
Level I – Generic drugs	Drugs listed on the Health Net Recommended Drug List (primarily generic)	\$5
Level II – Brand, preferred	Drugs and diabetic supplies (including insulin) listed on the Health Net Recommended Drug List (primarily brand name)	\$15
Level III	Drugs not on the Health Net Recommended Drug List	\$35

PRESCRIPTIONS BY MAIL

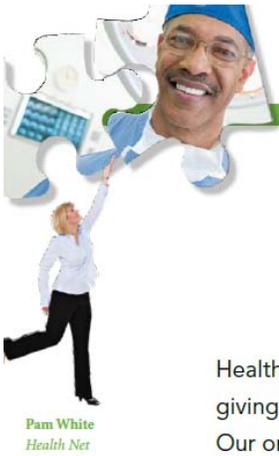
If your prescription is for a maintenance medication (a drug that you will be taking for an extended period of time), you have the option of filling it through our convenient and cost-saving Prescriptions By Mail Drug Program. Under this program, your copayments for up to a 90-day supply are: **\$10 level I / \$30 level II / \$70 level III**. For complete information, log on as a Health Net member at www.healthnet.com > *View prescription coverage* > *Get prescriptions by mail* or call Member Services at **1-800-676-6976**.

GENERIC SUBSTITUTIONS

Generic drugs will be dispensed when a generic drug equivalent is available, unless the prescription drug order states “do not substitute,” “dispense as written,” or words of similar meaning in the physician’s handwriting, in which case only the specific drug will be dispensed. However, when a generic drug equivalent is available and a brand name drug is dispensed, you must pay the following:

- The Level I drug copayment, plus
- The difference between the cost of the generic drug and the brand name drug.

However, if the prescription drug order states “do not substitute,” “dispense as written,” or words of similar meaning in the physician’s handwriting, only the Level II or Level III drug copayment, as appropriate, will be applicable.



Wellness Online

For Health Net members

Health Net is about more than just good health care benefits. It's about giving you all the tools you need to live a healthier, more productive life. Our online tools help empower you to make healthy lifestyle choices for you and your family. Here's how to get started:

Register

As a Health Net member, you have access to valuable online tools and programs. To take full advantage of these powerful tools, log on to www.healthnet.com and click on the *Register Now* button at the upper right corner of your screen. Take a few minutes to gather some personal information, and then log on for quick and easy registration:

- Subscriber ID # (from your Health Net insurance card)
- Your birth date
- Email address
- Create a user name and password

Shared decision making

Use unbiased health information resources to become as informed as possible about your area of concern, so that you can have a meaningful dialog with your doctor.

- Contact a Decision Power Health Coach
- Healthwise® Knowledgebase (online encyclopedia of medical information)
- Health Crossroads® Web modules (decision support, treatment options, and prevention tips)

Health Record

Health Record is used to store, maintain, track and manage your health information in one centralized, private and secure location.

- Track your Health Net medical claims, pharmacy claims, and your responses to the Health Risk Questionnaire, which are automatically imported.
- Add directly to your health record, including conditions, medications, allergies, visits, surgeries, immunizations and tests.
- Store and manage health care documents, such as advance directives, consent for treatment, diagnostic images, and test results.
- Print or fax your summary Health Record Report.
- Prepare a pre-visit questionnaire for your doctor that allows you to fit more than 30 minutes worth of relevant information into an average 7-minute visit.
- Print a convenient wallet-sized Emergency Information Card.
- Grant electronic access to your Health Record.

Health Risk Questionnaire

Our Health Risk Questionnaire (HRQ) is a comprehensive tool that:

- Provides you with an in-depth, holistic health analysis.
- Summarizes your prioritized health risk factors.
- Shows you how to reduce your risk for developing chronic conditions.
- Presents a personalized and insightful report.
- Presents an action plan with resources for improving your health.

Health Improvement Programs

Learn more about making better choices for a healthier future. Health Improvement Programs provide a highly interactive way for you to address and improve your risk factors, such as:

- Emotional health
- Exercise
- Nutrition
- Smoking cessation
- Stress management
- Weight management

For each topic, you may choose from the Full Program (Readings and Planner) or Planner Only.

- Readings are self-paced, and use incremental steps so as not to overwhelm the user.
- Planners provide tools and recommendations that help the user to implement and track tasks towards improving a specific risk factor, and graphically track progress.

Additional WebMD tools include Symptom Checker, video, newsletters, quizzes and calculators.

How a Health Coach can help



Your health.
Your coach.
Call today.

Did you know a Health Coach is there for you anytime, day or night, to help you?

Your Health Coach is a trained, caring health professional, such as a nurse, who has on average 10 to 15 years of experience.

To get the toll-free Health Coach number visit www.healthnet.com/ > Login [Register First Time Only] > Decision Power Health and Wellness > Talk to a Health Coach

Below are some health issues that may affect you and your family. Read the list and check off the ones you would like to learn more about. Are there other health topics that are not on this list? No problem – your Health Coach is there to help answer your health questions.

- anxiety
- asthma
- atrial fibrillation or a heartbeat that is not regular
- back pain
- benign prostate hyperplasia – also called BPH or an enlarged prostate
- cancer
- cardiometabolic risk management
- COPD – also called chronic obstructive pulmonary disease
- depression
- diabetes – also called high blood sugar
- fibromyalgia
- GERD – also called gastroesophageal reflux disorder
- heart disease – also called CHD or coronary heart disease
- heart failure
- high blood pressure – also called hypertension
- irritable bowel syndrome – also called IBS
- kidney disease
- knee and joint pain
- migraines
- osteoarthritis or swollen and stiff joints – also called OA
- osteoporosis or brittle, weak bones
- peptic ulcer disease
- pregnancy
- tobacco cessation
- weight management
- women's health issues

The toll-free Health Coach number is also listed on the back of your Health Net member identification card.

Health Dialog is contracted with Health Net, Inc. to provide services. Health Net. A Medicare Advantage organization with a Medicare contract. Material ID # Y0035_2012_0470 (H0351, H0562, H5439, H5520, H6815, EG); File & Use 11092011

 Health Net®

Español al dorso

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HCBLCL-PODFLI-HN-rev1

Benefit Highlights

Kaiser Permanente Senior Advantage 65+ (HMO) with Part D Plan Information

224606 City Of Victorville

Principal Benefits for Kaiser Permanente Senior Advantage (HMO) with Part D (7/1/12—6/30/13)

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary and in accord with Medicare guidelines
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Southern California Region Service Area, except where specifically noted to the contrary in the *Evidence of Coverage (EOC)*

Annual Out-of-Pocket Maximum for Certain Services

For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member)	\$1,500 per calendar year
For any one Member in a Family of two or more Members	\$1,500 per calendar year
For an entire Family of two or more Members	\$3,000 per calendar year

Deductible or Lifetime Maximum

None

Professional Services (Plan Provider office visits)

You Pay

Most primary and specialty care consultations, exams, and treatment	\$10 per visit
Annual Wellness Visit and the Welcome to Medicare Exam	No charge
Eye exams for refraction	\$10 per visit
Hearing exams	\$10 per visit
Urgent care consultations, exams, and treatment	\$10 per visit
Physical, occupational, and speech therapy	\$10 per visit

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures	\$10 per procedure
Allergy injections (including allergy serum)	\$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays, annual mammograms, and laboratory tests	No charge
Manual manipulation of the spine	\$10 per visit
Health education:	
Most individual health education counseling	\$10 per visit
Covered health education programs	No charge

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
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Emergency Health Coverage

You Pay

Emergency Department visits	\$50 per visit
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Note: This Cost Sharing does not apply if admitted to the hospital as an inpatient within 24 hours for the same condition for covered Services or if you are admitted directly to the hospital as an inpatient (see "Hospitalization Services" for inpatient Cost Sharing).

Ambulance Services

You Pay

Ambulance Services	\$125 per trip
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Prescription Drug Coverage

You Pay

Covered outpatient items in accord with our drug formulary guidelines:

Most generic items	\$10 for up to a 100-day supply
Most brand-name items	\$35 for up to a 100-day supply

Durable Medical Equipment

You Pay

Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	20 percent Coinsurance
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Benefit Highlights

Kaiser Permanente Senior Advantage 65+ (HMO) with Part D Plan Information (continued)

Mental Health Services	You Pay
Inpatient psychiatric hospitalization.....	No charge
Individual outpatient mental health evaluation and treatment	\$10 per visit
Group outpatient mental health treatment.....	\$5 per visit
Chemical Dependency Services	You Pay
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	\$10 per visit
Group outpatient chemical dependency treatment	\$5 per visit
Home Health Services	You Pay
Home health care (part-time, intermittent)	No charge
Other	You Pay
Eyewear purchased at Plan Medical Offices or plan optical sales offices every 24 months	Amount in excess of \$150 Allowance
Skilled nursing facility care (up to 100 days per benefit period).....	No charge (up to 20 days) \$75 per day (days 21–100)
External prosthetic devices, orthotic devices, and ostomy and urological supplies	20 percent Coinsurance

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the EOC. Please note that we provide all benefits required by law (for example, diabetes testing supplies).



My Health Manager

When you're a registered member on kp.org, you get a one-stop resource for managing your health online.* It offers time-saving features 24 hours a day, seven days a week. With My Health Manager, you can:

- E-mail your doctor's office
- View most lab test results
- Order prescription refills
- Request routine appointments
- View recent immunization records
- Use many of these same features on behalf of your child†
- Take a total health assessment and place a summary of your results in your electronic medical record

Your time and your health are important. Make them both a priority with My Health Manager. Learn more at kp.org/experience.

Classes and programs near you

Looking for new ways to meet familiar health challenges? Go to kp.org/classes to find health classes, support groups, and other programs available at your local medical facility. Class offerings vary by location, and some classes may require a fee. [i](#) *En español.*

Health guides A to Z

Health encyclopedia

We've got lots of pages (actually more than 40,000) with in-depth information on health conditions, related symptoms, and treatment options at kp.org/health. [i](#) *En español.*

Symptom checker

Use our interactive visual aid to assess your symptoms. Click on the part of the body that's troubling you and learn what to do next at kp.org/symptoms.

Drug encyclopedia

Look up detailed descriptions of thousands of drugs at kp.org/medications. Find out how to use a medication, its possible side effects, and any precautions you should take. You can search by drug name or medical condition. [i](#) *En español.*

Natural Medicines Comprehensive Database

Visit kp.org/naturalmedicines to find answers to your questions about dietary supplements, vitamins, minerals, and other natural products.

Look, listen, and learn

Get your health information to go. Download guided imagery audio programs and other wellness recordings at kp.org/listen. Or take in one of our health videos at kp.org/watch. [i](#) *En español.*

Interactive tools and calculators

Take a quiz or enter your information into one of our calculators to learn more about your health. Go to kp.org/calculators to find these interactive tools.

Healthy lifestyle programs

Together with HealthMedia®, we offer a personalized approach to improving your well-being with our healthy lifestyle programs.* Choose the program that's right for you and get a customized action plan that can help get your life headed in a healthier direction.

- Take a total health assessment with Succeed™
- Manage your chronic condition with Care™ for Your Health
- Lose weight with Balance™
- Eat healthy with Nourish™
- Manage diabetes with Care™ for Diabetes
- Quit smoking with Breathe™
- Reduce stress with Relax™
- Manage pain with Care™ for Pain
- Get a good night's sleep with Overcoming™ Insomnia
- Manage depression with Overcoming™ Depression

Start making positive changes today. Visit kp.org/healthylifestyles for more information.

[i](#) *En español. Visit kp.org/vidasana.*

Featured health topics

Get timely health information in one convenient place at kp.org/featuredtopics. You'll find a variety of resources on popular subjects, including:

- allergies
- arthritis
- asthma
- child and teen health
- colds and flu
- complementary and alternative care
- depression
- diabetes
- fitness
- healthy aging
- heart health
- making health decisions
- men's health
- mind and body health
- nutrition
- pain management
- pregnancy/new baby
- preventive care
- quitting smoking
- surgery
- weight management
- women's health

[i](#) *En español. Visit kp.org/tema.*



Try our free health assessment today

HealthMedia® Succeed™ is an easy online questionnaire that can help you examine what's affecting your overall health—from how often you exercise to what you eat in the morning—and then help you prioritize the lifestyle changes it recommends.

To find the total health assessment on **kp.org**, go to My Health Manager and choose "My medical record."* Once you've completed the online questionnaire, you'll receive a customized action plan to help you succeed in creating a healthier lifestyle.

To share this action plan with your Kaiser Permanente health care team, simply click on the option to share your information with them when you complete the online questionnaire, and a summary will be placed in your electronic medical record. When you come in for your next visit, you'll be able to discuss all the changes you want to make with your personal practitioner.

* This feature requires you to be registered and signed on to our Web site. If you haven't registered yet, start by going to **kp.org/register**.

Kaiser Permanente health plans around the country/planes de salud de Kaiser Permanente en el país: Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Ohio • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, (404) 364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Portland, OR 97232

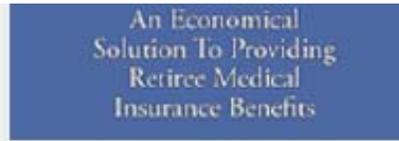
kp.org/healthylifestyles

KAISER PERMANENTE  **thrive**

Benefit Highlights

TAGCO Retiree Health Plan Information

Underwritten By: Hartford Life & Accident Insurance Company
(April 1, 2012 through December 31, 2012)



SENIOR MEDICAL INSURANCE PLAN

Part A Services

SERVICES	MEDICARE PAYS	HARTFORD PLAN PAYS	YOU PAY
HOSPITAL CONFINEMENT BENEFIT⁽²⁾			
Semi-private room and board, general nursing, and miscellaneous services and supplies:			
First 60 days	All but \$1,156	\$1,156	\$0
61 st through 90 th day	All but \$289 per day	\$289 per day	\$0
91 st through 150 th day (60 day Lifetime Reserve Period)	All but \$578 per day	\$578 per day	\$0
Once Lifetime Reserve days are used (or would have ended if used) additional 365 days of confinement per person per lifetime	\$0	100%	\$0
SKILLED NURSING FACILITY CARE⁽²⁾			
Semi-private room and board, skilled nursing and rehabilitative services and other services and supplies. You must meet Medicare's requirements which includes a hospital stay of at least 3 days. You must enter a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	\$0	\$0
21 st through 100 th day	All but \$144.50 per day	Up to \$144.50 per day	\$0
101 st through 365 th day	\$0	\$0	All costs
HOSPICE CARE			
Pain relief, symptom management and support services for terminally ill.			
As long as Physician certifies the need.	All costs, but limited to costs for out-patient drug and in-patient respite care	Co-insurance charges for in-patient respite care, drugs and biologicals approved by Medicare	All other charges
BLOOD DEDUCTIBLE – Hospital Confinement and Out-Patient Medical Expenses			
When furnished by a hospital or skilled nursing facility during a covered stay.			
First 3 pints	\$0	100%	\$0
Additional amounts	100%	\$0	\$0

Benefit Highlights
TAGCO Retiree Health Plan Information
Underwritten By: Hartford Life & Accident Insurance Company
(April 1, 2012 through December 31, 2012) (continued)

SENIOR MEDICAL INSURANCE PLAN - SUMMARY OF COVERAGE

Part B Services

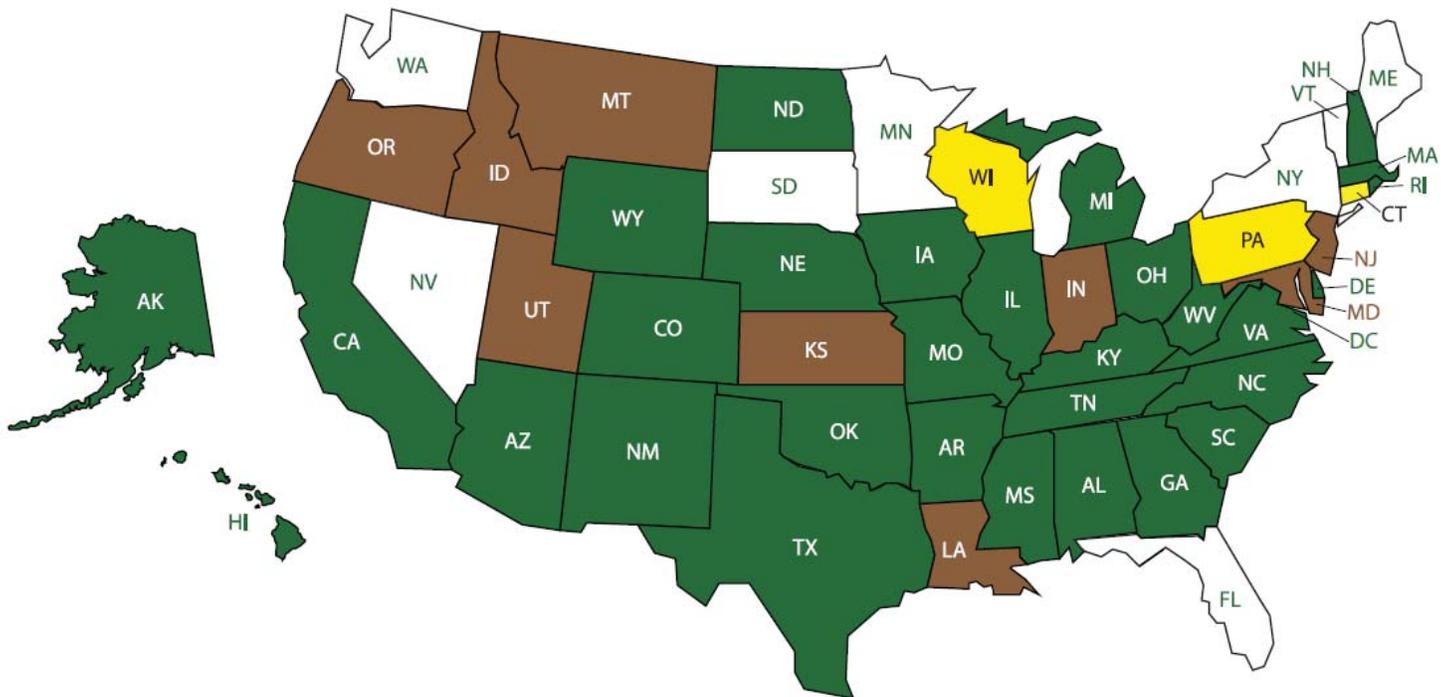
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
OUT-PATIENT MEDICAL EXPENSES - In or Out of the Hospital and Out-Patient Hospital Treatment, such as Physician's services, In-Patient and Out-Patient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment:			
Medicare Part B Deductible First \$140 of Medicare-approved amounts	\$0	\$140	\$0
Remainder of Medicare-approved amounts	Generally 80%	20%	0%
Clinical Laboratory services, blood tests, urinalysis and more	100%	\$0	\$0
Part B Excess Charges for Non-Participating Medicare providers covers the difference between the 115% Medicare limiting fee and the Medicare approved Part B charge.	\$0	100%	0%

Additional Services

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL EMERGENCY Medically necessary emergency care services.			
Emergency services needed due to Injury or Sickness of sudden and unexpected onset during the first 60 days while traveling outside the United States.	\$0	80% after \$250 Deductible (to a lifetime maximum of \$50,000)	\$250 Deductible and then 20% of expenses incurred (to a lifetime maximum of \$50,000, 100% thereafter)

¹ Coverage amounts valid from January 1, 2012 to December 31, 2012. This chart describes coverage that is only available to persons who are at least 65 and Medicare-eligible.

² A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.



A Case for The Hartford Group Retiree Health Insurance

GROUP RETIREE HEALTH INSURANCE EXPLAINED.

Looking to manage your retiree health benefits in an era of medical cost inflation, but have more questions than answers? Let The Hartford help. Use this handy guide to make the right decision for your company and your retirees.

Group retiree health (GRH) insurance—in a minute.

GRH insurance offers group retiree medical coverage that works with Medicare. The Hartford's fully insured group medical plan can cover many of the deductibles, copayments and out-of-pocket medical expenses that Medicare doesn't cover, like preventive care and at-home recovery services.

Not an HMO. A fully insured plan.

GRH insurance is a national, fully insured indemnity program. If the doctor or hospital accepts Medicare, coverage will integrate with Medicare. If the doctor or hospital doesn't accept Medicare, coverage will be payable as if they did accept assignments, and retirees may be responsible for any remaining balance.

Who's covered?

Retirees, their spouses, widow(er)s and domestic partners who are age 65+ and entitled to Medicare.

Plans for all groups and sizes.

Corporations, partnerships, individual employers, labor unions, religious organizations, Multiple Employer Trusts (MET), and most government agencies or departments (depending on state eligibility laws) are all considered eligible groups. Group sizes, ranging from as few as two to as many as thousands, are all eligible. Customized plans are available for groups of 100 or more.

Expertise without equal.

Benefits without burden.

GROUP RETIREE HEALTH INSURANCE EXPLAINED.

Good reasons to opt for a fully insured solution.

While self-insured retiree plans work well for some groups, there are many reasons to consider a fully insured solution.

- Groups currently providing retiree coverage, but looking to reduce and/or control costs.
- Older industries with a large group of retirees such as manufacturing, financial services, religious organizations, universities, hospitals, utilities, and public entities.
- Firms in financial difficulty (i.e., reorganization and bankruptcy) that are looking to shift liability.
- Contributory and noncontributory plans available.

Multiple billing options.

List bill, direct bill, or a combination of list and direct bill options are available. Individuals have the option to receive a paper bill or have funds auto-deducted from their bank account. Billing can be done monthly, quarterly, semi-annually or a combination of any of these.

Plus, Rx coverage options.

You can choose from a variety of prescription drug options for a better fit with your retirees' needs.

- Includes Medicare Prescription Drug Plans (PDPs) and non-Medicare creditable pharmacy coverage.
- A choice of plan designs.
- Retail and mail order coverage.
- Broad formularies of available medications.
- Reporting for Employers who apply for the tax-free subsidy from the Centers for Medicare and Medicaid Services (CMS).

Hassle-free, compassionate claims and customer service.

Electronic claims filing takes the wait out of the process. The doctor or hospital submits claims directly to Medicare. The Hartford uses its crossover system to electronically collect the claim from Medicare's system. As a result, usually no paper forms are needed. We provide a dedicated toll-free customer service number to help retirees with any issues that come up. Our customer service reps complete intensive training, including senior citizen sensitivity training. And they handle all inquiries, from billing to coverage questions.

Make the transition soon.

Switching to The Hartford's retiree health plan is easy. For more information, please contact your insurance advisor. To speak with a regional sales director at The Hartford, simply contact The Hartford Group Retiree Health Sales Contact line at **1-877-223-9782**, or visit our Web site at **www.groupretireehealth.com**.

Need more facts?

Just call your local Hartford representative. And visit our Web site at **thehartford.com/groupbenefits**. It's how smart benefit decisions begin.



Benefit Highlights

Express Scripts Retiree Prescription Drug Plan

Medicare Part D Prescription Drug Benefits Provided By Express Scripts Insurance Company

Deductible	None			
Member Co-Pays	Retail and Maintenance Drug Pharmacy			
		Up to a 1 Month Supply	Up to a 2 Month Supply	Up to a 3 Month Supply
	Generic	\$0	\$0	\$0
	Preferred Brand	\$15	\$30	\$45
	Non-Preferred Brand	\$30	\$60	\$90
	Specialty	\$30	\$60	\$90
	<p>Co-pays on applicable Part D drugs will double within the coverage gap but will be offset by the 50% discount provided as a part of the Medicare Coverage Gap Discount Program up to TrOOP. Co-pays on non-applicable drugs remain the same as above up to TrOOP.</p> <p><u>All</u> retail pharmacies in the Express Scripts network can provide you with up to a one-month or 31-day supply of your prescription</p> <p>To find out if your pharmacy is a Maintenance Drug Pharmacy (MDP) that has agreed to provide a three month or up to 90-day supply (with no co-pay savings) contact Express Scripts at the number listed on the back of the ID card</p> <p>Specialty Medications covered at CuraScript, Retail Pharmacies and MDP (when available)</p>			
	Express Scripts Home Delivery			
		Up to a 3 Month Supply		
	Generic	\$0		
Preferred Brand	\$30			
Non-Preferred Brand	\$60			
Specialty	\$60			
<p>You may receive up to a three-month or 90-day supply of maintenance drugs (drugs you take for a chronic condition, such as asthma) through Express Scripts Home Delivery.</p> <p>Note: The only way to obtain a three-month supply at the above co-pay savings is to use Express Scripts Home Delivery.</p>				
Catastrophic	Once the true out of pocket cost has reached \$4,700, the retiree will pay the following co-pay values: for generic drugs the greater of 5% or \$2.60 and for all other drugs the greater of 5% or \$6.50			
Utilization Management	Standard Part D			



Benefit Highlights

Assurant-UDC Dental California Prepaid DHMO Plan Information

BENEFIT HIGHLIGHTS	Plan General Dentist Member Copayment
ANNUAL DEDUCTIBLE	None
PLAN YEAR MAXIMUM	None
DIAGNOSTIC/PREVENTIVE Office Visit 0120-Oral Examination 1110-Prophylaxis cleaning 1203-Fluoride application 1351- Sealant per tooth	\$5 Charge No Charge No Charge No Charge \$10 Charge
X-RAYS 0210-Intraoral-complete series 0330- Full Mouth Series-panoramic	No Charge No Charge
MINOR RESTORATIONS 2140- Amalgam (Silver) Filling 2331-Composite Fillings (anterior teeth only)	No Charge No Charge
PERIODONTICS 4341- Scaling & Root Planning (per quadrant) 4210- Gingivectomy (per quadrant) 4260- Osseous Surgery (per quadrant)	\$40 Charge \$100 Charge \$250 Charge
ENDODONTICS 3220-Pulpotomy 3410-Apicoetomy (anterior) 3310- Endodontic Therapy (anterior teeth)	\$10 Charge \$125 Charge \$95 Charge
PROSTHODONTICS / MAJOR RESTORATIONS 2740-Crown Porcelain/Ceramic 5110-5140-Full & Partial Dentures 5510- Denture Repairs	\$185 Charge \$125 Charge \$30 Charge
ORTHODONTICS (limited to 24 months of active treatment) 8080-Comprehensive Treatment-Child to age 19 8090-Comprehensive Treatment-Adult 8680-Orthodontic Retention	\$1,695 Patient Charge \$1,895 Patient Charge \$95 Charge

Finding a Provider

You can find a Plan Dentist or Plan Specialist in the UDC Provider Network by visiting www.assurantemployeebenefits.com, clicking on the "Provider Search" link, and then selecting "CA UDC Prepaid". Availability of Plan Dentists and Plan Specialists varies depending on location.

Or go to our web site at:

www.assurantemployeebenefits.com

By Phone

HMO: 800-443-2995

1. Click on "CA UDC Prepaid" under Prepaid Managed Care Plans

2. This will bring you to the Provider search screen. Completing this screen will generate a list of all of all dentists based on your request.

This illustration is intended to provide only a partial list of Member benefits and copayments and does not reflect all benefits and copayments. It is not a Combined Evidence of Coverage and Disclosure Form. Please see the Combined Evidence of Coverage and Disclosure Form for a complete list of services covered by the Plan which determines all rights, benefits, and applicable limitations and exclusions.

Benefit Highlights

Assurant Employee Benefits Dental PPO Plan Information

City of Victorville Dental Insurance Benefit Summary

Presented by: Assurant Employee Benefits

Effective: July 1, 2012

Policy: 5458591

You are eligible to participate if you are a full-time employee, as defined by your employer, at active work and working in the United States. Other policyholder-defined eligibility requirements may apply. Temporary or seasonal workers are not eligible.

Plan Description

	In-Network	Out-of-Network	
Calendar Deductible – Individual	\$50	\$50	
Calendar Deductible – Family	3 individuals	3 individuals	
Deductible Applies	Class II & III	Class II & III	
Calendar Year Maximum Benefit	\$1,500	\$1,500	
Orthodontia	Applies to Adult & Child		
Orthodontia Deductible	None	None	
Orthodontia Lifetime Maximum	\$1,500	\$1,500	
Coinsurance	In-Network*	Out-of-Network	Highlights of Covered Services
Class I: Diagnostic & Preventive	100%	100%	Oral evaluations, routine cleanings, bitewing X-rays, fluoride treatments, sealants, intraoral complete series X-rays or panoramic film, genetic test for susceptibility to oral diseases.
Class II: Basic	90%	80%	Intraoral periapical X-rays, fillings, including tooth-colored fillings on posterior teeth, extractions, biopsy (including brush biopsy), periodontics, localized delivery of antimicrobial agents, root canal therapy.
Class III: Major	60%**	50%**	Crowns, dentures, fixed bridges, space maintainers, general anesthesia and intravenous sedation.
Class IV: Adult & Child Orthodontia	50%**	50%**	Orthodontic extractions, full or partial bands, appliances (removable and fixed).

* Dental Health Alliance, L.L.C.®, (DHA®) – To locate a participating provider, or to nominate your current dental provider, visit www.assurantemployeebenefits.com or call 800.985.9895. DHA is operated by Assurant Employee Benefits and owned by Union Security Insurance Company. DHA is Assurant Employee Benefits' dental PPO.

** A 12-month wait applies.

Pre-Estimation: If the charge for any dental treatment is expected to exceed \$300, Assurant Employee Benefits recommends a dental treatment plan be submitted to Claims for review before treatment begins.

"How to Find an Assurant PPO Network Dentist"

Web site Provider Search Directions:

By Phone
PPO: 800-442-7742

1. On our Home page, on the right Click on **"Find a Dentist"**
NEXT:

1. Click on **"Dental Health Alliance (DHA)"**

2. This will bring you to the Provider search screen. Completing this screen will generate a list all of all dentists based on your request.

Or go to our web site at:
www.assurantemployeebenefits.com

For more information regarding claims and services, please visit our website at:
www.assurantemployeebenefits.com or call us at 800.733.7879

This summary provides only a general overview and does not contain or describe all plan details. Issued insurance policies determine all plan features and policy benefits. Please consult your certificate or group policy for a complete description, including all applicable limitations, exclusions, reductions, and restrictions. Please contact Assurant Employee Benefits for additional information.

Vision Discount included with Assurant Dental PPO & Assurant-UDC Dental DHMO

VSP DISCOUNT SERVICES



Your dental plan includes a vision discount through Vision Service Plan (VSP). This includes discounts on exams (including contact lens exams) and the purchase of eyeglasses, sunglasses and other prescription eyewear when provided by VSP doctors. The VSP discount is available for you and everyone covered on your dental plan!

Services Available from a VSP Doctor

- **Eye Exams** – 20% discount applied to VSP doctor's usual and customary fees for eye exams¹
- **Glasses** – 20% discount applied to VSP doctor's usual and customary fees for complete pairs of prescription glasses and spectacle lens options²
- **Contact Lenses** – 15% discount off the contact lens exam (fitting and evaluation)².
- **Laser VisionCareSM** – VSP has contracted with many of the nation's laser surgery facilities and doctors, offering you a discount of 5% to 15% off PRK and LASIK surgeries, available through contracted laser centers

Other Valuable Features for You

- Immediate savings when using a VSP doctor
- You may use the discounts as often as you wish
- No waiting periods
- No deductibles
- No claim forms to fill out
- Toll-free customer service line and Web site for questions or grievances

This entitles you to a discount only. It is not insurance and is not intended to replace any vision plan or insurance coverage.



How to Use VSP

Locate a VSP doctor near you. You may either use our Web-based doctor locator at www.vsp.com, or call VSP at 800.877.7195 to request a doctor listing.

Identify yourself as being eligible for the VSP discount and be prepared to provide your UDC Member ID number when you make your appointment. (The VSP doctor will verify your eligibility and applicable discount. If you are not currently eligible for the discount, the VSP doctor is responsible for communicating this to you.)

Your fees are automatically reduced at the time of service – with no claim forms to fill out!

THIS VISION DISCOUNT OFFERED IS NOT INSURANCE.

¹Note: Does not apply to contact lens services. See contact lens section for applicable discount.

²Discounts only offered through the VSP doctor who provided an eye exam within the last 12 months.

VSP Member Services Support: 800.877.7195
Visit VSP's Web site at www.vsp.com

Benefit Highlights

MES VISION through Blue Shield of CA Plan Information

City of Victorville - Benefit summary

Exam copayment \$10, material copayment \$0, frame allowance \$200

Effective July 1, 2012

Using your vision plan

With this vision plan, you have access to an extensive network of vision providers in California and nationwide¹. Many of the providers are conveniently located in optical centers at retail stores such as Costco, LensCrafters, Wal-Mart, Sears, and Target Optical. You also can use an online network provider for 24/7 access to frames and lenses. When you use a network provider, most of your eyecare services are provided at no additional charge.

What your vision plan covers

Service and eyewear	Coverage when provided by network providers	Maximum payment when provided by non-network provider
Comprehensive Examination - every 12 months		
Ophthalmologic	100%	up to a maximum of \$60
Optometric	100%	up to a maximum of \$50
Lenses² - every 12 months		
Single Vision	100%	up to a maximum of \$43
Bifocal	100%	up to a maximum of \$60
Trifocal	100%	up to a maximum of \$75
Aphakic Monofocal or Lenticular Monofocal	100%	up to a maximum of \$120
Aphakic Multifocal or Lenticular Multifocal	100%	up to a maximum of \$200
Polycarbonate Lenses for Dependent Children	up to a maximum of \$100	up to a maximum of \$75
Frame - every 24 months	up to a maximum of \$200 ³	up to a maximum of \$40
Contact Lenses⁴ - every 12 months		
Non-Elective (Medically Necessary) - Hard ⁵	100%	up to a maximum of \$200
Non-Elective (Medically Necessary) - Soft ⁵	100%	up to a maximum of \$250
Elective (Cosmetic/Convenience) - Hard/Soft	up to a maximum of \$200	up to a maximum of \$120
Supplemental Low-Vision Testing and Equipment - covered up to \$1000 ⁵	75%	Not Covered
Plano (Non-Prescription) Sunglasses ^{4, 6}	up to a maximum of \$200 ³	Not Covered
Diabetes Management Referral ⁷	100%	Not Covered

LASIK discount program⁸

LASIK and PRK correction surgery, an alternative to contacts or glasses, is one of the fastest-growing vision treatments. The discount program gives covered employees access to:

- A 15% discount through the TLCVision provider network in California, or
- A 20% discount through the QualSight provider network in California.

Discount Vision Program⁸

Vision plan members can receive a 20% discount off the published retail prices when they use a participating California provider in the Discount Vision Program network for these services and supplies:

- Routine eye examinations
- Frames and lenses
- Photochromic lenses
- Hard contact lenses
- Tints and coatings
- Extra pair of glasses
- Non-prescription sunglasses

Find a network provider nearest you by going to the [Find a Provider](#) section on [blueshieldca.com](#), or calling Member Services at (877) 601-9083. You'll find a complete listing of ophthalmologists, optometrists, and opticians.

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CERTIFICATE OF INSURANCE AND POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.



2012 Summary of Employee Benefits Rates

<i>Medical - Health Net HMO Early Retirees-Under Age 65</i>	Total Monthly Premium
Employee Only	\$559.75
Employee + Spouse	\$959.41
Employee + Child(ren)	\$936.95
Employee + Family	\$1,217.99

<i>Medical - Kaiser Permanente HMO Early Retirees-Under Age 65</i>	Total Monthly Premium
Employee Only	\$597.32
Employee + Spouse	\$1,027.40
Employee + Child(ren)	\$997.53
Employee + Family	\$1,296.19

<i>Medical - Kaiser Permanente HMO Senior Advantage</i>	Total Monthly Premium
Subscriber with Medicare	\$178.85
Subscriber with Medicare + Spouse with Medicare	\$357.70

<i>The Hartford Group Retiree 65+ (04/01/12-12/31/12)</i>	Total Monthly Premium
Medical	\$242.82
Rx	\$224.46
Total Monthly Premium	\$467.28

<i>Dental - UDC Dental California, Inc. DHMO</i>	Total Monthly Premium
Employee Only	\$10.97
Employee + One	\$19.72
Employee + 2 or More	\$31.11

<i>Assurant Dental Health Alliance PPO</i>	Total Monthly Premium
Employee Only	\$34.55
Employee + Spouse	\$78.71
Employee + 2 or More	\$122.88

<i>Vision - Medical Eye Services through Blue Shield of CA</i>	Total Monthly Premium
Employee Only	\$12.49
Employee + Family	\$32.01

Retirement Savings Options - CalPERS

One Year Before Retiring

- Review your latest CalPERS Annual Member Statement.
- You can review it online or contact CalPERS at (888) CalPERS (225-7377) to request a copy.
- If you think you may be eligible to purchase additional service credit for employment not shown on your statement, you should review the information on Service Credit Purchase Options.
- Attend a CalPERS Retirement Planning Workshop or Financial Planning Seminar.

9 Months Before Retiring

- If you have a community property claim on your retirement benefits, you must provide CalPERS a copy of the court order resolving the claim before you can receive retirement benefits.
- If you aren't sure if CalPERS has this information, or you have questions on your court settlement and your benefits, contact CalPERS.
- If you are also a member of another public retirement system in California, you will have to file for retirement separately with each system; however, your benefits could be based on the highest compensation earned under all systems, if you retire from each on the same date.

6 Months Before Retiring

- Consider getting a retirement benefit estimate.
- Use the information from your Annual Member Statement to get an estimate using the Retirement Planning Calculator.
- You can also [request an Official CalPERS Estimate](#) online or by contacting CalPERS.
- If you're considering electing the optional Temporary Annuity benefit, you should also get an estimate of your Social Security benefits from the Social Security Administration.

4 to 5 Months Before Retiring

- Begin working on your Service Retirement Election Application form. Ensure time for your employer to complete their required fields.
- Begin to gather and make copies of some of the required documents. (Remember, only send CalPERS copies of these materials - never send originals.)
- There is a Required Documents Checklist in the application package that you can refer to before you send in your application.
- Send the completed application to CalPERS 90 days before your retirement date.

Some Documents You May Need to Include

- Marriage or Domestic Partnership Certificate
 - This is needed if you are a State or school member, or a public agency member whose employer contracts for the Survivor Continuance benefit; or if you will be naming your spouse as your beneficiary.
- Your beneficiary's Birth Certificate
 - This is needed if you are considering one of the options to provide continuing benefits to a beneficiary after your death; or you have a child under the age of 18 or a child who became disabled before age 18 who is eligible for the Survivor Continuance benefit.

3 to 4 Months Before Retiring

- Finish completing the application.
- Contact CalPERS at (888) CalPERS (225-7377) to make an appointment to review your application. They can answer any questions you have about your retirement options.
- Check out the other forms in the package and see if you will need to use them (based on your situation).
- Review any deferred comp plans that you plan to use for retirement with your financial advisor.
- If you have not already, communicate your intent to retire with your supervisor.
- Complete and submit a retirement letter.



Retirement Savings Options - Great West 457 Plan and ICMA-RC 401(a)

Great West 457 Plan

The 457 Deferred Compensation Plan is a voluntary supplemental retirement savings program that allows you to make pre-tax contributions into your Great West account through payroll deductions.

With a 457 Plan:

- Earnings are tax-deferred until withdrawn.
- You may reduce current taxable income taxes while investing for retirement.
- Payroll deduction changes will be processed by Great West.
- The 457 contribution limit for 2012 has increased to \$17,000.

If you are within one of the three years ending before you reach normal retirement age, then you may utilize the Standard Catch-Up provision. With the Standard Catch-Up, you may be able to contribute up to an additional \$17,000 in 2012. This amounts to a total contribution up to \$34,000 in 2012.

For participants who are 50 years of age or older during the calendar year, you may contribute an additional amount into the 457 plan for all plan years except the years in which you utilized the Standard Catch-Up provision. The additional amount is \$5,500 in 2012, up to \$22,500. Please note that this Age 50+ Catch-Up provision and the Standard Catch-Up provision cannot be utilized in the same calendar year.

- Contributions to this account along with any earnings that accumulate are taxed upon distribution. The IRS does impose restrictions on when these funds can be accessed. Upon complete separation from City service, participants may elect to withdraw a portion or all of your 457 account balance. You would be responsible for federal and state taxes on the amount withdrawn. There is no penalty for withdrawals made from a 457 plan prior to the participant's attainment of age 59 ½, based upon the IRS guidelines.

Introducing an Easy and Convenient New Way to Enroll in Your Plan

Step One:

Once you have learned about your Plan and are ready to enroll, access the online enrollment section of the website and click on *Let's Get Started* under the login boxes at: www.gwrs.com

Step Two:

Enter your Plan ID, then click continue.

Step Three:

You should automatically receive a Personal Identification Number (PIN) by mail at your home address. Each account owner is responsible for keeping the assigned PIN confidential. Once you receive your PIN, proceed to Step Four. If you have not yet received your PIN but are ready to enroll, please call KeyTalk at 1.800.701.8255, #); ask the Retirement Plan Specialist for a temporary PIN. With your temporary PIN, you may continue to Step Four.

Step Four:

Enter your Social Security number (SSN) and PIN, then click continue.

Step Five:

Enter your paycheck contribution amount (a dollar amount or percentage between 1% and 100% of your compensation, as allowed by the Plan) that you want to contribute to the Plan from each paycheck.

Step Six:

Review and agree to the Participation Agreement for Online Enrollment, then click, *Enroll Me*. You will receive an enrollment confirmation message. **Print the confirmation screen for your records.**

Step Seven:

Click continue to review your account features online.

Reminder: Now that your account is open, it is important to designate a beneficiary. Click on the beneficiary link under the **My Profile** icon and follow the online instructions.

You may visit www.gwrs.com or call 1.800.933.9808 to enroll in your Plan today.

ICMA-RC 401(a)

There is a 401(a) Defined Contribution Plan available for new full-time employees who may elect an individual employee contribution, under Section 401(a) of the Internal Revenue Code. The plan document allows a 60 day period for the individuals to make an election from the initial date of hire. Each participant has an individual plan account to which contributions are made. As a qualified plan participant, you are not taxed on contributions, nor upon earnings, until they are withdrawn, usually at retirement. Pursuant to Federal Regulations, effective December 31, 2009, existing full-time employees may not enroll or modify an existing 401(a) plan. You may access your account balance by calling ICMA-RC at 1.800.669.7400 or electronically through ICMA's website at www.icmarc.org by choosing "Account Access" and it will provide you with further instructions to register for first time users to this site.

Important Notices

HIPAA: Health Insurance Portability and Accountability Act

The Group Health Plan you are enrolling in *may* impose a pre-existing condition limitation or exclusion on new enrollees for a period of 12 months from the start of your waiting period. For a newly-hired employee, the start of your waiting period is typically the day you begin work for this employer. If your plan imposes a waiting period, that time will count toward satisfaction of any pre-existing limitation or exclusion. A pre-existing condition is defined as a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period ending on the start date of your waiting period.

Due to Health Care Reform, effective January 1, 2011 this limitation will not apply to children under age 19.

In addition, any pre-existing condition, exclusion, or limitation will be reduced by the total time an individual was covered by another group or governmental health program, provided there was not a breach of coverage of more than 63 days. Late entrants will have an 18-month, pre-existing limitation/exclusion imposed with credit given for any previous creditable coverage as explained above.

No pre-existing condition limitation or exclusion may be applied to a pregnancy, a newborn child, or a child placed for adoption, provided the child has coverage within 30 days of the date of birth or placement for adoption.

The 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 delivery. 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.



The Women's Health and Cancer Rights Act

Your health plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call your health plan's Member Services department for more information.

COBRA

Under a law called the Consolidated Omnibus Budget Reconciliation Act (COBRA), you have the right to continue your medical, dental and vision plan participation beyond when your coverage would normally end. To do so, you must pay the full cost of medical, vision and dental coverage, plus 2%. The duration of continued coverage through COBRA depends on your situation (called a qualifying event), as follows:

- If your employment is terminated (for reasons other than gross misconduct) or your hours are reduced so that you are no longer eligible, you may continue health coverage for yourself and dependents for up to 18 months.
- If your dependent loses coverage because of divorce, legal separation, your death, or if your child reaches the maximum eligible age, that dependent may continue health coverage for up to 36 months.
- If you or your dependent becomes disabled (as defined by Social Security) before or within 60 days after starting COBRA coverage, the disabled person may have up to 29 months of COBRA coverage from the date he or she was first eligible. You must pay an additional amount for this extended coverage.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free or Low Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

You may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility – The following information is current as of February 16, 2010.

CALIFORNIA – Medicaid
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-866-298-8443

To see if any more States have added a premium assistance program since February 16, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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, Ext. 61565

OMB Control Number 1210-0137 (expires 07/31/2010)

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE PART D

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CITY OF VICTORVILLE and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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.

CITY OF VICTORVILLE has determined that the prescription drug coverage offered by Health Net and Kaiser, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE PART D (continued)

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from **October 15th** through **December 7, 2012**. Beneficiary's leaving employer coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

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

You should also know that if you drop or lose your coverage with CITY OF VICTORVILLE and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage...

Contact the CITY OF VICTORVILLE office for further information. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this medical coverage through CITY OF VICTORVILLE changes. You also may request a copy.

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 prescription drug plans. For more information about Medicare prescription drug plans:

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see 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.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Date: July 1, 2012
Name of Entity: CITY OF VICTORVILLE
Contact: Human Resources
Address: 14343 Civic Drive, Victorville CA 92392

Remember: Keep this Creditable Coverage notice with your important Health Insurance paperwork. 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).

Important Notices Regarding Health Care Reform

The following changes have been made to the above-referenced health plan (the "Plan"). The changes are effective July 1, 2012.

1. Coverage of Adult Children Through Age 25

The Plan will offer an opportunity to enroll adult children for coverage under the Plan, subject to the following limitations:

- Coverage will be offered for children through age 25.
- Children must be enrolled according to the terms of the Plan.
- Coverage of enrolled children will cease at age 26 unless applicable law requires us to offer coverage for a longer period of time.

2. No Lifetime Limits on the Dollar Amount of Essential Health Benefits

No lifetime limit on the dollar amount of essential health benefits will be imposed under the Plan. Non-essential health benefits may be subject to a lifetime limit on the dollar amount of such benefits. The Plan Administrator will determine whether or not a particular benefit is essential using good faith efforts to comply with a reasonable interpretation of the term "essential health benefits" as that term is described in the Patient Protection and Affordable Care Act.

3. Annual Limits on the Dollar Amount of Essential Health Benefits

There is no annual dollar limit on essential health benefits. Non-essential health benefits may be subject to an annual limit on the dollar amount of such benefits. The Plan Administrator will determine whether or not a particular benefit is essential using good faith efforts to comply with reasonable interpretation of the term "essential health benefits" as that term is used in the Patient Protection and Affordable Care Act.

4. Updated Appeals Process and New External Review Process

A rescission of coverage is treated as an adverse benefit determination that is covered by the Plan's applicable claims and appeal process. A claim for urgent care will be reviewed as soon as possible, taking into account medical emergencies, but not later than 24 hours after receipt of a claim that contains sufficient information. Please note that this paragraph will be effective July 1, 2011 if your plan year begins between September 23, 2010 and July 1, 2011. If you plan year begins after July 1, 2011, this paragraph will be effective on the first day of your plan year. For example, if your plan year begins January 1, 2011, then this paragraph will be effective July 1, 2011. If your plan year begins September 1, 2011, then this paragraph will be effective September 1, 2011.

If you wish to appeal a denial of benefits or a coverage determination, you will be permitted to review your claim file and present evidence and testimony as part of the Plan's claims and appeals process. You will receive any new or additional evidence considered, relied upon, or generated by the Plan in connection with your claim. If the Plan intends to issue a final internal adverse benefit determination that is based on a new or additional rationale, the Plan will provide you with the rationale and you will have an opportunity to respond prior to the final benefit determination.

You will receive continued coverage pending the outcome of an internal appeal for certain claims that involve an ongoing course of treatment. You may be eligible to participate in an external review process in which your claim may be reviewed by an independent third party.

5. Preventive Health Coverage

Subject to some limitations, the Plan will provide benefits for the following categories of in-network preventive health services ("Preventive Services") and will not impose any cost sharing with respect to such benefits:

- Evidence-based items or services that have in effect an A or B rating in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved;
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the guidelines supported by the Health Resources and Services Administration.

Important Notices Regarding Health Care Reform (continued)

The complete list of Preventive Services that will be covered can be found at <http://www.HealthCare.gov/center/regulations/prevention/recommendations.html>.

If a Preventive Service is not billed or tracked separately from another item or service, the Plan may impose cost sharing requirements if the primary purpose of the office visit is not the delivery of a Preventive Service. The Plan may impose cost-sharing requirements for Preventive Services provided by out-of-network providers. The Plan may use reasonable medical management techniques to determine the frequency, method, treatment or setting for Preventive Services, unless otherwise specified by applicable law.

6. Coverage of Emergency Services

The Plan's rules regarding coverage of emergency services have changed. Emergency services generally must be covered without any prior authorization, even if the services are provided on an out-of-network basis. They also must be covered without regard to whether the provider is a participating network provider. If the emergency services are provided out-of-network, the Plan cannot impose any administrative requirement or limitation that is more restrictive than ones imposed on in-network providers. The Plan also must follow new cost-sharing rules when emergency services are provided out-of-network. The services must be covered without regard to certain other terms and conditions (but not including some terms and conditions, including coordination of benefit provisions).

IMPORTANT Notice of Opportunity to Enroll Children Who Were Previously Ineligible by Reason of a Dependent Eligibility Threshold

This is to notify you that effective July 1, 2012 due to a change in applicable law, your children generally can be covered under the Plan until they attain age 26, regardless of their student or marital status and regardless of whether your home is their principal place of abode or whether you support them. Thus, children whose coverage under the Plan ended, who were denied coverage, or who were not eligible for coverage, because the availability of dependent coverage of children under the Plan ended before attainment of age 26 may be eligible for coverage under the Plan beginning July 1, 2012. Coverage is not available to children who have attained age 26 or who will attain age 26 on or before July 1, 2012. In order for an adult child to be covered under the Plan, you must also be enrolled for coverage.

Notes

Notes



2012 RETIREE BENEFITS GUIDE

Alliant Insurance Services, Inc.
701 B Street, 6th Floor
San Diego, CA 92101-8156
License No. 0C36861

I hereby agree to hold harmless the City of Victorville and Alliant Insurance Services, Inc. for information contained within this general outline of benefits from any and all liability, loss, damages, costs or expense which are sustained, incurred, or required.

The information in this brochure is a general outline of the benefits offered under City of Victorville benefits program. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Insurance Certificate, Booklet, Booklet-Certificate, Group Policy) to determine governing contractual provisions relating to your plan. Specific details and plan limitations are provided in the Evidence of Coverage and Disclosure Form. In the event the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

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