# Employee Benefits

# Overview

**Effective: 1/1/13 through 12/31/13**

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# Eligibility Guidelines

The City of Merced offers a cafeteria style employee benefits program. Employees have a choice of options within each coverage offered for the medical, dental, vision, life and disability. Additionally, employees have an option to buy supplemental voluntary products at a cost but with the convenience of a payroll deduction. The benefits program is designed to meet the specific individual and family needs of each eligible employee. Please see below for specific "waiting periods" for each coverage effective dates.

## Medical Insurance

Medical insurance will be effective upon the date of hire for eligible employees and their eligible dependents.

## Dental & Vision Insurance

Dental and vision insurance will be effective the first of the month following the completion of 6 months of continuous employment with the City of Merced, for eligible employees and their eligible dependents.

## Life Insurance

The "core" life insurance will be effective upon the date of hire for eligible employees. Employees also have a "Buy-Up" option to purchase additional life insurance for both themselves and their eligible dependents.

## Disability Insurance

The "core" disability insurance will be effective the first of the month following the completion of 6 months of continuous employment with the City of Merced for eligible employees. Public Safety employees will have a 30-day waiting period for such insurance. Employees also have a "Buy-Up" option to purchase additional disability insurance.

## Cafeteria Plan

The cafeteria plan is made available to all eligible employees upon their date of hire.

## Supplemental Voluntary Products

The supplemental voluntary products are made available to all eligible employees during each annual open enrollment period.

**These Benefits Are Effective January 1, 2013**

The information in this brochure is a summary only of the benefits offered under the City of Merced's benefit program. Specific details and plan limitations are provided in your individual Evidence of Coverage (EOC), which is based on the official Plan Documents that may include policies, contracts and plan procedures. Please refer to your EOC or Summary Plan Description for details. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

## Adding and Removing Dependents

You are responsible for notifying Support Services (209) 388-7100 of any changes in your dependent status during the plan year (Divorce, Marriage, Birth or Adoption and adding or removing dependents). All Qualified Life Event changes must be made within 30 days from the date of the event. A copy of the marriage certificate or adoption paperwork may be required for this kind of change. Failure to submit notification in a timely manner may impact dependent eligibility for health care continuation under COBRA which may result in you incurring liability for medical expenses for the non-eligible dependents. All changes will be effective the first of the month following the qualifying event date.

All employees adding dependents may be required to submit documentation verifying eligibility of their covered dependents. The following chart is an easy guide to which form and documents may be submitted.

For further clarification, please contact the Support Services department, (209) 388-7100.

| | Nothing Required | Marriage Certificate Required | Dependent Verification* | State of California Domestic Partner Registration Required |
|---|---|---|---|---|
| Employee only | x | | | |
| Employee & Spouse | | x | | |
| Employee & Domestic Partner | | | | x |
| Employee & Child(ren) | | | x | |
| Employee, Spouse or Domestic Partner & Child(ren) | | x | x | x |

* Dependent verification includes birth certificate or a legal document stating legal guardianship of the dependent.

# When You Can Make Changes to Your Benefits

Other than during the annual "open enrollment" period, you may not change your coverage/participation unless you experience a qualifying event.

Qualifying events include:

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

**Important—making changes to your benefits during the year:**

- You must make the changes within 30 days of the date the *event* (marriage, birth, etc.) occurs.

## When Your Benefits Terminate

- Health insurance benefits will terminate on the last day of the month of the event of termination (retirement, unpaid absence or exhausting FMLA leave period).
- When terminating, the employee must work at least one full schedule day in the month to get coverage for that month.
- COBRA, if elected, will be effective the first of the month following date of termination.

## Benefits during the Family and Medical Leave (FMLA) and California Family Rights Act (CFRA)

An employee taking family/medical leave will be allowed to continue participating in any health and welfare benefit plan in which he/she was enrolled before the first day of leave (for a maximum of 12 work-weeks) at the level and under the same conditions of coverage as if the employee had continued in employment for the duration of such leave. The City will continue to make the same premium contributions as if the employee had continued working. The continued participation in health benefits begins on the date leave first begins under the Family and Medical Leave Act (e.g. for pregnancy disability leaves) or under the Family and Medical Leave Act/CFRA (e.g. for all other family care and medical leaves).

In some instances, The City may recover premiums paid to maintain health coverage for you if you fail to return to work following pregnancy disability leave/FMLA leave.

An employee's use of family/medical leave will not result in the loss of any employment benefit that the employee earned before using family/medical leave.

**All employees must notify Support Services at (209) 388-7100 as soon as possible for requesting FMLA for your own illness or for caring for a family member.**

# Medicare and the Active Worker

If you are an active employee and have reached the age of 65, you may be wondering about Medicare. You should receive an advisory notice from Medicare about 4 months before your 65th birthday for your initial enrollment period. Here is some information that you should know about your Medicare options when working beyond age 65:

- You must stay in the Group Health medical plan until you retire or are otherwise not eligible for the group plan.

- You have the option of enrolling in Medicare Part B (medical) coverage at your cost. If you do so, your Group Health medical plan remains your primary and Part B (which does have a fee involved) would coordinate as secondary coverage to your Group Health medical plan.

- When you reach age 65, you must complete the Group Health Certification of Medicare Status form to report either your enrollment in Medicare Part B or your deferment until retirement.

- Once you retire with Group Health Medical Plan, you must sign up for Part B with Medicare during the eight months following the month that your health plan coverage or employment ended (whichever is first), also known as the Special Enrollment Period.

- If you choose to defer Part B, please be aware that there may be a 10% federal surcharge added to the monthly premium for every 12 month period that you were qualified to sign up for Medicare but did not enroll.

- Upon retirement, you will be transferred to the Medicare plan, assuming that you meet other eligibility requirements.

**For additional information on Medicare and your options, contact Support Services at (209) 388-7100 or go to www.medicare.gov.**

# Benefit Plan Contact Information

**Below is a list of toll-free numbers you can call with questions about benefit coverage or available providers in your area. Each company's website provides access to provider information and additional programs available to you and your family.**

| Benefit Plan & Carrier | Member Services: (for claims, eligibility and benefit inquiries) | Website: |
|---|---|---|
| **Medical Coverage:**<br>Anthem Blue Cross (EPO) | 1-800-967-3015 | www.anthem.com/ca |
| **Prescription Drug Coverage:**<br>Medco Health | 1-800-711-0917 | www.medcohealth.com/medco/consumer/home.jsp |
| **Dental Coverage:**<br>Delta Dental PPO | 1-888-335-8227 | www.deltadentalca.org |
| **Vision Coverage:**<br>Vision Service Plan (VSP) | 1-800-877-7195 | www.vsp.com |
| **Life/AD&D/Voluntary Life/LTD:**<br>ING | 1-800-955-7736 | www.ing.com |
| **City of Merced Insurance Department**<br>Andrew Guzman<br>Rosa Winzer | 1-209-385-6979<br>1-209-385-6867 | guzmana@cityofmerced.org<br>winzerr@cityofmerced.org |

# Medical Benefits

| General Plan Information | Blue Cross EPO | |
|---|---|---|
| | Core Benefit | Buy-Up Option |
| Annual Deductible<br>• Member<br>• Family | **$100**<br>**$300** | None<br>None |
| **Maximum Plan Year Copayment/Coinsurance**<br>• Member<br>• Family | **$1,500**<br>**$3,000** | $1,000<br>$2,000 |
| **Lifetime Maximum Benefit** | Unlimited | Unlimited |
| Hospital | **Inpatient - $100 / day for 1st 3 days**<br>**Outpatient - $100 / admit** | No Charge |
| Physician Office visits | **$20/visit** | $10/visit |
| Preventive Care | No Charge (deductible waived) | No Charge |
| Diagnostic X-Ray and Lab | No Charge (deductible applies) | No Charge |
| Emergency Room (facility only) | **$200**<br>waived if admitted | **$100**<br>waived if admitted |
| Ambulance | $50 | $50 |
| Durable Medical Equipment | **20% of Allowed Charge** | 50% of Allowed Charge |
| Speech / Physical Therapy / Occupational Therapy | **$20 (deductible applies)** | $10 |
| Mental Health | | |
| Inpatient | **$100 / day for 1st 3 days** | No Charge |
| Outpatient | **$20** | $10 |
| | | |
| **Prescription Drugs (*30-day supply*)** | | |
| Generic | **$7** | $10 |
| Formulary Brand Name | **$25** | $20 |
| Non-formulary | 100% of the Medco discounted price | 100% of the Medco discounted price |
| **Mail Order Program (*90-day supply*)** | | |
| Generic | **$14** | $20 |
| Formulary Brand Name | **$60** | $40 |
| Non-formulary | 100% of the Medco discounted price | 100% of the Medco discounted price |
| **Mandatory Retail Refill Allowance Program*** | Yes | Yes |

Note: This summary is for informational purpose only. It does not amend, extend, or alter the current policy in any way. In the event information in this summary differs from the Plan Document, the Plan Document will prevail.

* The Retail Refill Allowance (RRA) applies to maintenance prescriptions refilled at a Retail Pharmacy. If you choose to continue to fill your maintenance prescription at a retail pharmacy, at the 4th fill and beyond the Retail copay will increase to the Mail Order copay level for 30 day supply.

# Dental Benefits

| General Plan Information | Delta Dental Core Benefit | Delta Dental Buy-Up Option |
|---|---|---|
| **Non-PPO Annual Deductible** | | |
| Per Person | $25 (out-of-network only) | $25 (out-of-network only) |
| Family | $75 (out-of-network only) | $75 (out-of-network only) |
| | | |
| **Maximums** | | |
| Annual | $1,000 | **$1,500** |
| Lifetime Orthodontic | $1,000 | **$1,500** |
| | | |
| **Covered Services** | | |
| Diagnostic and Preventive | 100% | 100% |
| Basic Benefits | 100% | 100% |
| Major | 100% | 100% |
| Orthodontia | 100% | 100% |

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# Vision Benefits

| General Plan Information | VSP – Choice Network Core Benefit | VSP – Choice Network Buy-Up Option |
|---|---|---|
| Exam | $25 | $25 |
| Materials | **$25** | included with exam copay |
| Frequency of Services | | |
| • Exam | 12 months | 12 months |
| • Lenses *OR* Contacts | **24 months** | 12 months |
| • Frames | **24 months** | 12 months |
| Annual Allowances | | |
| • Frames | $120 | $120 |
| • Contacts in lieu of Frames | $120 | $120 |
| **NON-MEMBER DOCTOR** | | |
| Benefits: (amount reimbursed, less deductible) | | |
| Vision Exam | Up to $45 Paid | Up to $45 Paid |
| Lenses (Pair) | | |
| - Single Vision | Up to $30 Paid | Up to $30 Paid |
| - Bifocal | Up to $50 Paid | Up to $50 Paid |
| - Trifocal | Up to $65 Paid | Up to $65 Paid |
| - Lenticular | Up to $100 Paid | Up to $100 Paid |
| Frame | Up to $70 Paid | Up to $70 Paid |
| Contact Lenses (in lieu of other eyewear) | | |
| - Medically Necessary | Up to $210 Paid | Up to $210 Paid |
| - Elective | Up to $105 Paid | Up to $105 Paid |

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# Life and AD&D Benefits

| General Plan Information | Core Benefit |
|---|---|
| **Core Life Benefits** | 1x annual earnings up to $50,000 |
| **Guarantee Issue Amount** | 1x annual earning up to $50,000 |

| General Plan Information | Buy-Up Option |
|---|---|
| **Eligible Employees:** | All Active Employees Under Age 80 |
| **Buy-up Life Benefits:** | |
| **Employee Benefit** | |
| Maximum | $100,000 – Not to exceed 5 times employees annual salary |
| Election Options | $10,000; $20,000; $40,000; $50,000; $60,000; $80,000; $100,000 |
| Guaranteed Issue Amount | $100,000 |
| Employees over Age 70 | Maximum benefit is $50,000 |
| **Spouse Benefit** | |
| Maximum | Up to $50,000 |
| Election Options | $5,000; $10,000; $20,000; $30,000; $40,000; $50,000 |
| Guaranteed Issue Amount | $50,000 |
| **Dependent Child(ren) Benefit** | |
| Birth – 14 Days | $0 (Birth to 13 Days) |
| 14 days to 6 months | $250 (14 Days – 6 Months) |
| 6 months to 19 years (to 25 yrs if FT Student) | $10,000 (6 Months to 19 years, 25 if FT student) |
| Guaranteed Issue Amount | $10,000 |

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# Disability Benefits

| General Plan Information | Core Benefit | Buy-up Option |
|---|---|---|
| **Employee Classes** | White Collar Employees<br>All Other Active Employees | |
| **STD & LTD Benefit** | | |
| **Salary Covered** | 60% | 66.67% |
| **Maximum Monthly Benefit** | | |
| STD – All Classes | $600/week | $1,650/week |
| LTD – All Classes | $2,500/month | $7,000/month |
| **Minimum Monthly Benefit** | $100 | $100 |
| **Elimination Periods**<br>White Collar for STD<br>All Other Classes for STD<br>All Classes for LTD | <br>30 days<br>60 days<br>22 weeks (180 days) | |

The City of Merced offers an integrated disability plan that is designed to be simpler and more cost effective for employees. This feature includes a **Short-Term Disability** plan which allows for weekly payments during your initial disability period up to 22 weeks (180 days). If your disability exceeds 22 weeks (180 days), your payments will convert to a **Long-Term Disability** plan and you will receive monthly payments for the duration of your disability per contract definitions. If you continue to be disabled, you are automatically assigned a **Long-Term Disability** benefit.

**Core Disability Benefits**

1. The "core" benefit is paid for by the City of Merced.
2. The Short-Term Disability plan starts after the elimination period has been satisfied and pays a weekly benefit of 60% of your weekly salary to a maximum of $600 a week. The duration of the Short Term Disability benefit is 22 weeks (180 days), minus the elimination period.
3. The Long-Term Disability benefit is paid on a monthly basis and covers up to 60% of your monthly salary up to a maximum of $2,500 a month. The duration of the Long Term Disability benefit is to age 65 or your normal social security retirement age as long as you meet the definition of disability.

**Buy-Up Disability Benefits**

As an employee, you will also have the opportunity to purchase additional benefits:

1. STD Buy-up to 66.67% of your weekly salary to a maximum of $1,650 a week. The duration of the Short Term Disability benefit is 22 weeks (180 days), minus the elimination period.
2. LTD Buy-up to 66.67% of your monthly salary up to a maximum of $7,000 a month. The duration of the Long Term Disability benefit is to age 65 or your normal social security retirement age as long as you meet the definition of disability.

If you are interested in purchasing the "Buy-Up" Disability benefits, please see Human Resources for an enrollment form.

Note: This summary is for informational purpose only. It does not amend, extend, or alter the current policy in any way. In the event information in this summary differs from the Plan Document, the Plan Document will prevail. All employees under the Fire MOU will have long-term disability benefits provided through CSFA Firefighter long-term disability plan.

# Additional Information Regarding Your Benefits

## The Newborns & 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 (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 their issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## The Women's Health & 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 a reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call your health plan's Members Services for more information

## Important Notice About You And Your Dependent Child's Health Insurance Enrollment Rights

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 is an update to the Children's Health Insurance Program that expired in September 2007. This updated version was signed into law by President Obama on February 4, 2009 and becomes effective on April 1, 2009. It extends the program through Fiscal Year 2013.

<u>What this means for you and your dependent child(ren):</u>

If you or your dependent child is eligible but not enrolled in the City group health plan, and you meet either of the following conditions, you have special enrollment rights:

- You or your dependent child is covered under a Medicaid plan or a CHIP plan and you or your dependent child's coverage under such a plan is terminated as a result of loss of eligibility for such coverage, as long as you request coverage under the City group health plan no later than 60 days after the date of termination of coverage.
- You or your dependent child becomes eligible for premium assistance, as to coverage under the group health plan under such Medicaid plan or CHIP plan, as long as you request coverage under City's group health plan no later than 60 days after the date you or your dependent child are determined to be eligible for assistance.

Should you have any question regarding your special enrollment rights, please contact the Support Services Department at (209) 388-7100.

# Additional Information Regarding Your Benefits

## Health Insurance Portability & Accountability Act

The Blue Cross EPO Plan you are enrolling (may) impose a pre-existing condition limitation or exclusion on new enrollees according to the following guidelines:

No payment will be made for services or supplies for the treatment of a *pre-existing condition*. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period prior to your coverage under this *plan*. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were subject to a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The *pre-existing condition* exclusion does not apply to pregnancy or to a child who is enrolled in the *plan* within 31 days after birth, adoption, or placement for adoption.

**This exclusion may last up to six months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period (see "Eligibility Date" under the section HOW COVERAGE BEGINS AND ENDS). However, you can reduce the length of this exclusion period by the number of days of your prior *creditable coverage*. Most prior health coverage is *creditable coverage* and can be used to reduce the *pre-existing condition* exclusion if you have not experienced a significant break in coverage. The maximum allowable break in coverage is 180 days if your prior coverage was provided through an employer and ended because your employment (or the person's employment through whom you had this coverage) ended, the availability of coverage through employment or sponsored by an employer has terminated, or an employer's contribution toward health coverage has terminated. For prior coverage that was not provided through an employer, such as individual coverage or coverage through a government program such as Medicaid, the maximum allowable break in coverage is 63 days. Please see "Creditable Coverage" in the DEFINITIONS section of your Evidence of Coverage for a complete list of the types of coverage for which credit is given.**

**To reduce the six-month exclusion period by your *creditable coverage*, you should give us a copy of any certificates of creditable coverage you have. There is no time limit within which you must provide a certificate in order to receive credit for your prior coverage. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or carrier. There are also other ways that you can show you have *creditable coverage*. Please contact us if you need help demonstrating *creditable coverage*. All questions about the *pre-existing condition* exclusion and *creditable coverage* should be directed to the customer service telephone number listed on your identification card.**

**Notice of Availability of HIPAA Privacy Notice**

**We are required by federal and state law to protect the privacy of your individually identifiable health information and other personal information. City of Merced is committed to maintaining and protecting the confidentiality of our employees' personal and sensitive information.**

# Important Notice from the City of Merced about your Prescription Drug Coverage and Medicare

## Important Notice from the City 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 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.**

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

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

- The City has determined that the prescription drug coverage offered by the City 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.

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**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 7th through November 15th.

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 current City coverage will not be affected. The City provided prescription plan is credible and Medicare eligible's are allowed to purchase additional prescription drug coverage through Medicare. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

**If you do decide to join a Medicare drug plan and drop your current City coverage, be aware that you and your dependents may not be able to get this coverage back.**

# Important Notice from the City of Merced about your Prescription Drug Coverage and Medicare

**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 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 November to join.

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

Contact the City's Support Services Department at (209) 388-7100.

**NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

| | |
|---|---|
| Date: | January 1, 2013 |
| Name of Entity: | City of Merced |
| Contact: | Support Services Department |
| Address: | 678 W 18th Street, Merced, CA 95340 |
| Phone: | (209) 388-7100 |

City of Merced

"Gateway to Yosemite"

**Employee Benefits Brochure designed and developed by**

In conjunction with the City of Merced – October 2012