Retiree Benefits Guide

2023

CITY OF GLENDALE, CALIFORNIA
Human Resources
Civil Service Commission

613 E. Broadway, Suite 100
Glendale, CA 91206-4308
Tel. (818) 548-2110
glendaleca.gov

City of Glendale Benefit Waiver Form

Name: _____

☐ New Hire ☐ Active Employee ☐ Retiree

Employee ID: _____

Social Security (last 4): _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Waiver of Coverage:

I have been offered the opportunity of participating in the City of Glendale's health insurance program and have chosen to waive the following plans:

☐ Medical (*Only ACA eligible benefit available)
☐ Dental
☐ Vision
☐ Supplemental or Retiree Life (if applicable)

My reason is:

☐ Cost
☐ Other Group Coverage - please specify coverage: _____
_____
☐ Other: _____

Additional Notes (if any): _____

Please discontinue my coverage with the following effective date: _____
(Note: Effective date must be the 1st of the designated month (cannot be retroactive).

_____ _____
Signature Date

Form can be scanned and emailed to Benefits@glendaleca.gov or faxed to Benefits at (818) 243-8428.

2023 Monthly Rates: Retirees

EFFECTIVE JUNE 1, 2023 - MAY 31, 2024

ANTHEM BLUE CROSS - California Retirees

	Total Monthly Premium with Medicare	Total Monthly Premium without Medicare
Single	$444.81	$1,452.34
Two-Party (1 Medicare)	$1,897.15	$3,717.95
Two-Party (2 Medicare)	$889.62	N/A
Family (1 Medicare)	$4,162.76	$5,272.03
Family (2 Medicare)	$1,334.43	N/A

ANTHEM BLUE CROSS - Out-Of-State Retirees Only

	Total Monthly Premium with Medicare	Total Monthly Premium without Medicare
Single	$444.81	$1,472.41
Two-Party (1 Medicare)	$1,917.22	$3,769.13
Two-Party (2 Medicare)	$889.62	N/A
Family (1 Medicare)	$4,213.94	$5,344.46
Family (2 Medicare)	$1,334.43	N/A

ANTHEM HIGH DEDUCTIBLE HEALTH PLAN - Early Retirees Only

	Total Monthly Premium without Medicare
Single	$1,251.29
Two-Party	$2,627.70
Family	$3,753.84

ANTHEM BLUE CROSS - California Care HMO - California Retirees

	Total Monthly Premium with Medicare	Total Monthly Premium without Medicare
Single	$481.53	$1,327.22
Two-Party (1 Medicare)	$1,808.75	$2,787.10
Two-Party (2 Medicare)	$963.06	N/A
Family (1 Medicare)	$3,135.97	$3,981.33
Family (2 Medicare)	$1,444.59	N/A

2023 Monthly Rates: Retirees

EFFECTIVE JUNE 1, 2023 - MAY 31, 2024

KAISER PERNAMENTE HMO - California Retirees

	Total Monthly Premium with Medicare	Total Monthly Premium without Medicare
Single	$153.68	$1,446.91
Two-Party (1 Medicare)	$1,600.59	$2,893.82
Two-Party (2 Medicare)	$307.36	N/A
Family (1 Medicare)	$2,801.53	$4,094.76
Family (2 Medicare)	$1,508.30	N/A

KAISER PERNAMENTE DEDUCTIBLE HMO - California Early Retirees Only

	Total Monthly Premium without Medicare
Single	$1,199.28
Two-Party	$2,398.55
Family	$3,393.95

GUARDIAN DENTAL

	High Option PPO (*only with Anthem PPO)	Buy-Up PPO	MDC-G90 DMO
Single	$41.44	$34.03	$18.36
Two-Party	$70.45	$57.82	$33.63
Family	$107.74	$88.46	$51.33

VSP VISION

	VSP
Single	$7.67
Two-Party	$15.34
Family	$24.70

ICMA-RC is now

MissionSquare RETIREMENT

VantageCare Retirement Health Savings (RHS) Plan

Benefits Reimbursement Request Form

- Complete this form and send with supporting documentation to **VantageCare RHS Plan, c/o Meritain Health, Inc., P.O. Box 30136, Lansing, MI 48909-7611** or fax to 888-665-8495 for processing. Alternatively, you may submit reimbursements and documentation online via Account Access (www.icmarc.org/login). Select your RHS plan and then Claims to get to the Meritain Health claims portal.
- For privacy and security reasons, MissionSquare Retirement removed Social Security Number as an identifier on this form. Please provide your MissionSquare Reference Code instead of your Social Security Number. If you do not know your Reference Code, it is available through Account Access on the My Profile tab and on your MissionSquare statements.
- Each form of documentation must contain the date(s) of service, provider name, provider address, description of treatment, service or supply, amount charged, insurance payments, as well as the name of the claimant. ***Supporting documentation may consist of: Itemized Bills, Explanation of Benefits, Premium Notices, Itemized Receipts.***
- Eligible claim expense(s) for reimbursement must be incurred on or after your eligibility date. Generally, claims should be submitted within two years from the date of the expense, but this limit may vary among plans. If you have questions regarding this limit or your claims, please contact Meritain at 888-587-9441.

PLEASE NOTE – SIGNATURE IS REQUIRED FOR PROCESSING: ***Do not*** submit claims for charges eligible under your insurance or Medicare. A medical care expense may not be reimbursed from a Flexible Spending Account (FSA) if the expense has been reimbursed or is reimbursable under any other accident or health plan. If a medical care expense is eligible for coverage by both a Health Reimbursement Arrangement (HRA) and a health FSA, amounts available under a HRA must be exhausted before reimbursement may be made from a health FSA. This requirement does not apply to medical care expenses which are reimbursed from a health FSA but are not reimbursable by a HRA. In no case may a participant be reimbursed for the same medical care expense by both a HRA and a health FSA. ***Do not*** submit claims for services provided prior to your benefit eligibility date. Claims are processed upon receipt of documents in good order.

If you are able to access funds from your RHS plan in the same year in which you contribute to your Health Savings Account (HSA) administered through another provider, please consult your tax advisor prior to submitting reimbursement to your RHS account. There are specific rules governing HSAs when an employee is also enrolled in a HRA, like the RHS plan, that may affect the tax treatment of the HSA contributions.

PART A PLAN AND PARTICIPANT INFORMATION

EMPLOYER PLAN NUMBER:	EMPLOYER PLAN NAME:	STATE:
800115	CITY OF GLENDALE	CA

FULL NAME: *LAST, FIRST, MI*

REFERENCE CODE:	PREFERRED PHONE NUMBER:	EMAIL ADDRESS:

MAILING ADDRESS:

STREET *CITY* *STATE* *ZIP*

NOTE: If this is a new address, please contact MissionSquare at 800-669-7400 to update your address. Your check will be mailed to the address on file with MissionSquare.

PART B REQUEST FOR REIMBURSEMENT OF NON-RECURRING EXPENSES

Use this section to request a reimbursement of non-recurring expenses *(e.g., co-payments, medications, out-of-pocket expenses).*

Summary of Healthcare Expenses

Incurred Date*	Applicant's Full Name (last, first, middle initial)	Provider (e.g., doctor name/ pharmacy name)	Claim for (self, spouse, dependent child, other dependent)	Description of Service	Amount to be Reimbursed
					$
					$
					$
				Total reimbursement request:	$ 0.00

**Incurred date is the date of service, not the billing or payment date.*

MissionSquare Retirement ■ Attn: Workflow Management Team ■ P.O. Box 96220 ■ Washington, DC 20090-6220 ■ Toll Free 800-669-7400 ■ www.icmarc.org ■ Fax (202) 682-6439

50874-0321-C1333

PARTICIPANT NAME: LAST, FIRST, MI	REFERENCE CODE:

PART B REQUEST FOR REIMBURSEMENT OF NON-RECURRING EXPENSES *(CONTINUED)*

READ CAREFULLY AND SIGN BELOW FOR PROCESSING.

The undersigned certifies all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participant's spouse, or the participant's eligible dependents while the undersigned was eligible to receive benefits under the RHS Plan. The undersigned also certifies as follows:

- The medical expenses have not been reimbursed and are not reimbursable under any other health/dental plan or Medicare.
- The undersigned is responsible for requesting cessation of automated reimbursement of recurring expenses when the expense is no longer being incurred, and will retain sufficient documentation for all recurring expenses. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

The undersigned understands he/she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. The undersigned understands he/she will be liable for payment of all related taxes including federal, state, or local income tax on amounts paid from the Plan for non-qualifying expenses.

Signature: _____ Date: MM/DD/YYYY _____

USE THIS SECTION TO REQUEST AUTOMATED REIMBURSEMENT OF RECURRING EXPENSES (e.g., insurance premiums).

Note: *Payment must be made to the account holder. Payment will not be made directly to an insurance company or other third party.*

You are responsible for ensuring automated reimbursements are for qualifying medical expenses. You are also responsible for ensuring automated reimbursements are stopped if you are no longer incurring the expense(s). You must provide documentation of the recurring expense with this request, and you must retain sufficient documentation for all recurring expenses. Supporting documentati on must show the premium is paid with after-tax funds and include the following: (i) Insurance Carrier; (ii) Type of Insurance; (iii) Policy Holder's Name; (iv) Amount; and (v) Coverage Period. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

1. ☐ **BEGIN** recurring reimbursement of $_____
   Beginning Date – insert date you wish payments to begin: MM/DD/YYYY _____
   Frequency *(Check one)*: ☐ Annual ☐ Quarterly ■ Monthly
   Ending Date – insert date of last payment: MM/DD/YYYY _____
2. ■ **CHANGE** recurring payment amount from $_____ to $_____
   Effective date of change: MM/DD/YYYY 06/01/2023
3. ☐ **END** recurring payment of $_____
   Ending Date: Insert date of last payment: MM/DD/YYYY _____

Note: *Payments will continue until your account is depleted, unless an ending date is provided. Any changes to your payment must be received by Meritain Health at least 10 business days prior to next payment. Otherwise the change will take effect on the next scheduled reimbursement.*

PARTICIPANT NAME: *LAST, FIRST, MI*	REFERENCE CODE:

PART B REQUEST FOR REIMBURSEMENT OF NON-RECURRING EXPENSES *(CONTINUED)*

READ CAREFULLY AND SIGN BELOW FOR PROCESSING.

The undersigned certifies all expenses for which reimbursement or payment is claimed by submission of this form were incurred by the participant, the participant's spouse, or the participant's eligible dependents while the undersigned was eligible to receive benefits under the RHS Plan. The undersigned also certifies as follows:

- The medical expenses have not been reimbursed and are not reimbursable under any other health/dental plan or Medicare.
- The undersigned is responsible for requesting cessation of automated reimbursement of recurring expenses when the expense is no longer being incurred, and will retain sufficient documentation for all recurring expenses. Meritain Health, Inc. reserves the right to periodically request documentation for all automated payment requests.

The undersigned understands he/she alone is fully responsible for the sufficiency, accuracy, and veracity of all information relating to this claim. The undersigned understands he/she will be liable for payment of all related taxes, including federal, state, or local income tax on amounts paid from the Plan for non-qualifying expenses.

Signature: _____ Date: *MM/DD/YYYY* _____

PLEASE RETAIN A COPY FOR YOUR RECORDS.

Send completed form to:

VantageCare Retirement Health Savings (RHS) Plan
c/o Meritain Health, Inc.
P.O. Box 30136
Lansing, MI 48909-7611

888-587-9441

MERITAIN® HEALTH

An Aetna Company

Want to file a claim using the RHS Participant claims portal?

Step 1—ensure your documentation is in good order!

Prior to submitting your claim(s), you should check your available balance and obtain the appropriate supporting documentation.

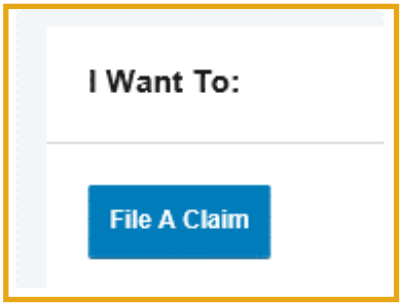
Common examples include:

- Premium Itemization Notice.
- Explanation of Benefits (EOB).
- Itemized statements or bills.

For more information on supporting documentation, review the ***Necessary Documentation for In Good Order Submissions***

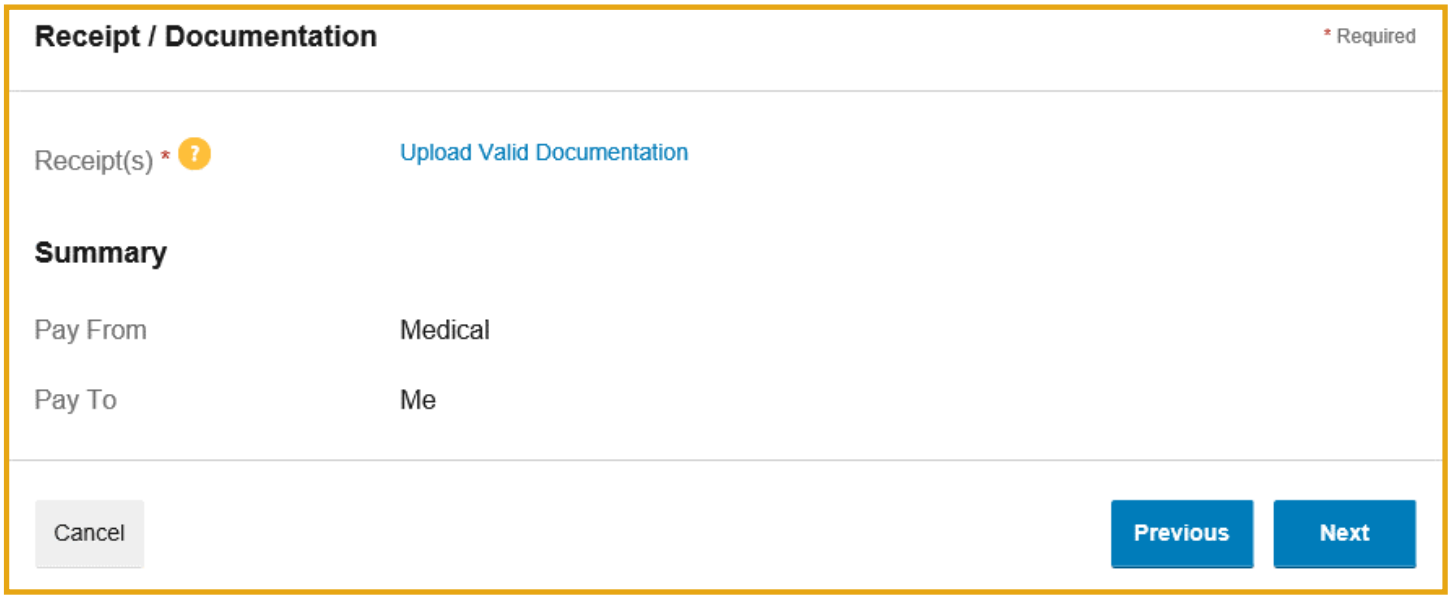
Step 2

Click on *file a claim* to start the process.



Step 3

You will be prompted to upload your supporting documents.

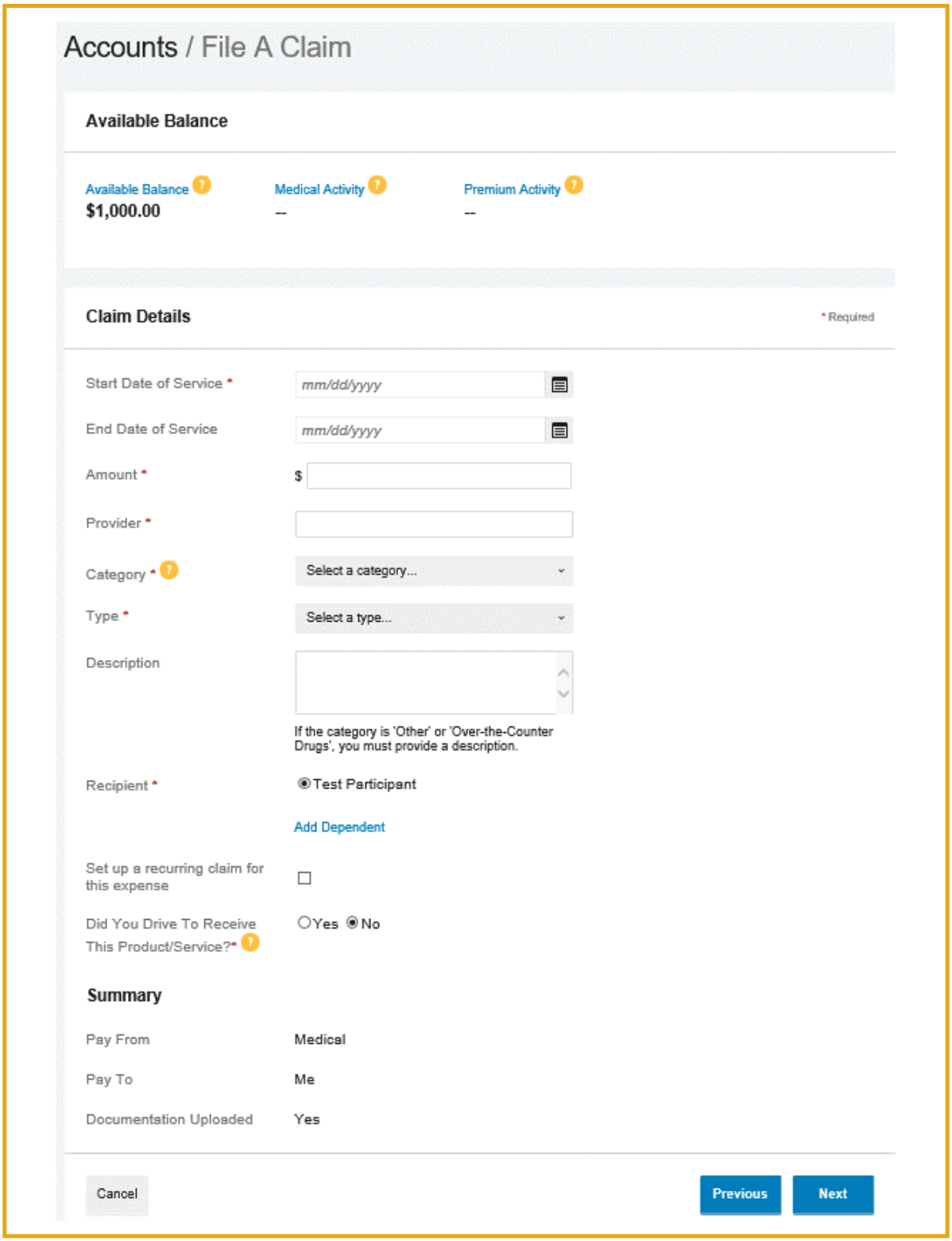


Step 4

Enter your claim details-mandatory fields are indicated with an asterisk (*). Required fields:

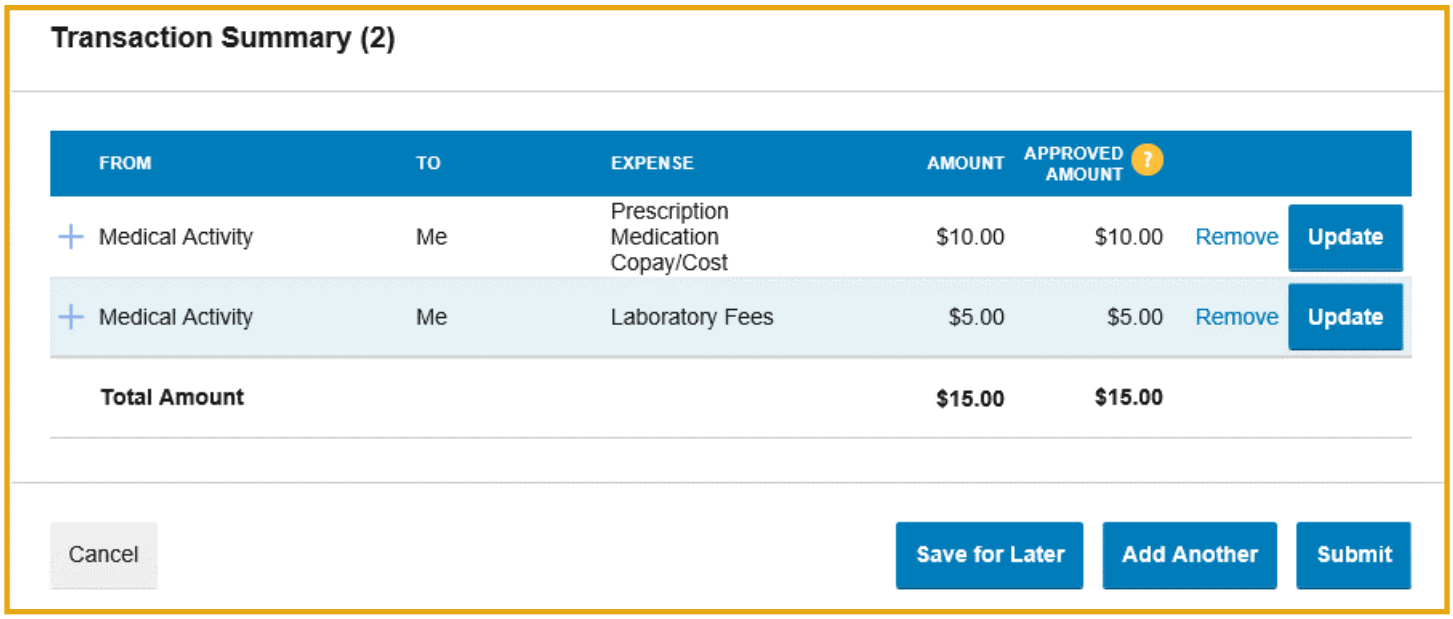
- Date of service
- Amount
- Provider
- Category and claim type
- Recipient (select dependent if applicable)

You can establish a recurring claim by selecting this option as shown below:



Step 5

Click *Add Another* to file more than one claim. In order to process your claims on time, please itemize them. Claims must be broken down by expense type and date of service.



Additional information

- **To add a spouse/dependents**—Select *Accounts*, then *Profile Summary*, and *Add Dependent* to provide this information
- **To establish Direct Deposit**—Select *Tools & Support* and *Change Payment Method* to set up Direct Deposit

Have any questions, or need more information? We can help. Please contact the Meritain Health Customer Service team at 1.888.587.9441, weekdays 8:00 AM–5:00 PM ET or by Missionsq@meritain.com

MERITAIN® HEALTH
An Aetna Company

Futuris Care Medicare Exchange Tips

As an integral part of the City of Glendale's ongoing effort to increase options for our retirees, Medicare eligible retirees (and dependents) will have the option of obtaining health care coverage by participating in the Futuris Care Medicare Exchange.

City of Glendale
Human Resources
613 E. Broadway, Room 100 Glendale, CA 91206
Phone (818) 548-2160
Fax (818) 243-8428

https://www.glendaleca.gov/government/departments/human-resources/benefit-information/retirees

City of Glendale

California

1. Anthem Blue Cross Members
California Blue Cross PPO
Senior Secure HMO
Out-of-State Blue Cross FFS

You may enroll in an individual Medicare plan by calling a Benefits Advisor to review your options. The Advisor will shop all the plans in your area to find one that meets your needs.

2. Kaiser Medicare Members

At this time, the Kaiser Senior Advantage plan does not participate in the Medicare Exchange. As such, you are able to continue on with your current Kaiser coverage through the City of Glendale.

You may call a Futuris Care Benefits Advisor to answer any questions you may have or to help you find an alternative plan that meets your personal needs.

If you do not have an interest in the Futuris Care Medicare Exchange, you do not need to do anything. Should you speak with a Benefits Advisor, let them know you plan to remain on the group Kaiser plan and they will note that in their system.

3. Open Enrollment

Open Enrollment is the time for retirees to make changes to their current medical, dental (if applicable) and vision insurance elections.

Open Enrollment: Mid-April to Mid-May

Medicare Exchange Premiums

Retirees who enroll in the Futuris Care Medicare Exchange for coverage that begins June 1st or later, will pay the first month's premium at the time of enrollment directly to the insurance carrier they select.

Retirees who have an RHSP account with MissionSquare Retirement (formerly ICMA-RC) will not be able to receive their reimbursement until they have an invoice as receipt from the insurance carrier.

4. Medicare Exchange Translation

If you call a Futuris Care Benefits Advisor to inquire about a plan through the Futuris Care Medicare Exchange, here are helpful translations of the terms used in the Medicare Exchange World:

Anthem Blue Cross Senior Secure Plan	=	Medicare Advantage Plan
Anthem PPO or Fee For Service (FFS)	=	Medigap Plan (Plan F) + Prescription Drug Plan

For more information on Futuris Care, visit

www.healthcompare.com/futuriscare

or call
Futuris Care Benefits Advisors

1-888-616-7130

Retiree Benefits Guide 2023

1. General Information

10. Core Benefits

31. Other Benefits

36. Miscellaneous

NEW! Click this icon ▶ in your benefits guide to watch a video explaining the associated topic.

NEW! See page 49 for a glossary of terms.

If you (and/or your dependents) have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 42 for more details.

This Guide gives you an overview of your benefits including eligibility, plan options, how to enroll and other important information. More detailed information is available in the official plan documents. In the event of a conflict between this information and your plan contract, the terms of the contract will prevail.

Introduction

Annual Open Enrollment

Getting the most value from your benefits depends on how well you understand your plans and how you use them. Benefits are important; they provide support to you when you need it the most. They're also a personal choice; your life circumstances change from year to year and your financial and protection needs may change as well.

Take action during the City's open enrollment to review your family's changing needs, evaluate your existing coverage, and decide whether to continue with your current choices or make a change. Use the many resources available to make well-informed decisions about your benefits for the coming year. Being proactive now will ensure that you and your family have the coverage you need throughout the year ahead.

Important Dates

As a City of Glendale retiree, you may use this open enrollment period (mid-April through early May) as an opportunity to make changes to your current medical, dental and vision insurance elections (as applicable).

Read this Open Enrollment Guide carefully to understand how your benefits package works. Review the materials enclosed in your open enrollment package.

What To Do Now

If you want to keep the same coverage and dependents, you do not need to enroll or make any changes.

Making Changes to Your Benefits

If you are adding / removing dependents from coverage, or changing your coverage, Enrollment and Change Forms are available from Benefits or online at https://www.glendaleca.gov/government/departments/human-resources/benefit-information/retirees

  - Benefits 818.548.2160
  - benefits@glendaleca.gov

- **Medicare Age Retirees – Post 65:** Futuris Care / Medicare Exchange is still available as an alternate option to the City's Retirement Medical Programs.

Keep in mind that after the Open Enrollment period, you **cannot change** your benefit elections during the year unless you have a qualifying life event.

If you are not making any changes, there is nothing for you to do. All benefits will remain the same.

Introduction (continued)

IRS Guidelines

You may make changes to your benefits outside of the Open Enrollment period only if you experience certain "life events" designated by the IRS. The list below defines some of the acceptable situations where a change is permitted outside of open enrollment:

- You marry, divorce, become legally separated or your marriage is annulled
- You establish or terminate a Domestic Partnership
- You gain a dependent through birth or adoption
- Your dependent dies
- Your dependent no longer meets the eligibility requirement (i.e., over age)
- You or your spouse have a change in employment status that results in gaining or losing eligibility for benefits coverage

Any change that you make in your coverage must be made *within 30 days* of the qualifying life event and must be consistent with that event.

If your life event allows you to add or remove dependents, contact Benefits. Keep in mind that HMO and PPO contracts do not allow you to add new dependents after the 30-day period.

REMOVING DEPENDENTS

Dependents will lose coverage the first of the month following loss of eligibility.

Note, if divorced, you **MUST** notify the City **WITHIN 30 DAYS** of final divorce date.

ADDING DEPENDENTS

Must add **WITHIN 30 DAYS** of qualifying event (marriage, birth, etc.)

Eligibility

The benefits you're eligible to enroll in may depend on your designated Employee Association at retirement.

Retiree Eligibility

If you are a retired salaried employee of the City, you may be eligible for retiree health benefits.

Dependent Eligibility

If you are eligible to participate in the City's health benefits, so are your eligible dependents at your retirement (consistent with the plan terms and contracts).

- Your legal spouse or domestic partner
- Your dependent children who are under age 26

Over-Age Dependents

Health care reform legislation has mandated that group health plans (Anthem Blue Cross Prudent Buyer PPO, HDHP, CaliforniaCare HMO, Kaiser Traditional, Kaiser Deductible DHMO, Guardian, and VSP Vision) offer coverage to dependent children until they attain age 26.

Important Notes About Dependent Eligibility

1. Your former spouse or domestic partner, parents, parent-in-law, other relatives, and dependent children 26 years old and over are not eligible for coverage under the City's health benefits.
2. You must drop coverage for your enrolled spouse, domestic partner or dependent child when he/she loses eligibility (e.g., divorced or terminated domestic partnership, your child attains age 26).

Health Plan Options

Plans Available for Retirees Living in California

Non-Medicare Participants

- Anthem Blue Cross Prudent Buyer PPO 80 / 60 Plan
- Anthem Blue Cross High Deductible Health Plan (HDHP)
- Anthem Blue Cross CaliforniaCare HMO
- Kaiser Permanente Traditional HMO
- Kaiser Permanente Deductible HMO
- KeenanDirect

Medicare Participants

- Anthem Blue Cross Medicare Advantage Plan (MAPD Plan)
- Anthem Blue Cross Senior Secure HMO
- Kaiser Senior Advantage HMO
- Futuris Care / Medicare Exchange

Plans Available for Retirees Living Out-of-State

Non-Medicare Participants

- Anthem Blue Cross Blue Card Network PPO
- Anthem Blue Cross High Deductible Health Plan (HDHP)

Medicare Participants

- Anthem Blue Cross Medicare Advantage Plan (MAPD plan)
- Futuris Care / Medicare Exchange

Futuris Care for Medicare Retirees

The City of Glendale has partnered with Futuris Care to assist Medicare retirees with finding coverage to fit the needs of every individual. Medicare retirees have many options available to them that may vary depending on where you live and the type of coverage that is needed. Futuris Care is a Medicare Exchange which allows you to shop for individual Medicare plans in the area you live.

- Open enrollment dates are October to December for a January 1 effective date.
- Online information and enrollment can be accessed through the website at www.medicare.healthcompare.com/futuriscare. The website has the ability for you to enter your current prescription drugs you are taking and it will search the plans that cover your prescriptions.
- If you would prefer to contact a Benefit Advisor on your own you may do so at 888.616.7130, Monday through Friday, 6:00 AM to 6:00 PM, and they can do the same search on your behalf. Please make sure you tell the benefit advisor that you retired from the City of Glendale to ensure they have added the correct affiliation.
- **Possible Premium Savings:** Although premiums vary depending on your age, gender, and zip code, the average premium for retirees from the City of Glendale who enrolled in a Futuris Care plan is approximately $150.

It is important to be aware of all the options you have available to you. The Futuris Care Benefit Advisors are there to help you by answering questions and finding coverage alternatives that may end up saving you money.

KeenanDirect

Helping You Choose the Right Direction for Your Individual and Family Plans and Small Group Health Solutions

Everyone Will Need Health Insurance

Keenan & Associates now provides direct access to health plans for individuals, families and small employer groups including plans available through Covered California. We make your search to find the right coverage quick and convenient!

- **Toll-Free, Personalized Service:** Dedicated toll-free number 855.359.7354, Monday through Friday, 8:00 AM to 6:00 PM. Speak with a Keenan representative to explore the plans and products available in the Individual market.
- **Online Information and Enrollment:** Located at www.KeenanDirect.com. Use the cost calculator to determine subsidy eligibility, get a quote for plan options and check out provider networks. Access all of the major carriers and learn more about the Covered California Exchange subsidies, and plans available in and out of the Exchange.

Keenan & Associates already serves more than 250,000 Californians for their health care coverage. Through www.KeenanDirect.com, we can help navigate the new marketplace and identify individual, family and small employer group health care solutions. With a phone call or click of a mouse, get help today!

The City of Glendale has partnered with KeenanDirect to assist retired employees who are interested in getting insurance coverage.

Individual and Family Plans

- Retired Employees
- Special enrollment periods for major life events such as changes in employment or family situations – call us to find out if you qualify
- Covered California enrollment assistance
- Get tax credits – Ask us if you qualify

We are your advocate and offer enrollment assistance and expert guidance, FREE of charge.

- Access to major California carriers and health plans
- **Full Suite of Insurance Products:**
  - Health
  - Dental
  - Vision
  - Life
  - Accident
  - Cancer

About KeenanDirect

As a leading health insurance broker with over 40 years of experience, we offer one-stop access to major carriers and plans available in California. This includes the Covered California exchange because KeenanDirect is a Covered California Certified Insurance Agent.

The City of Glendale dedicated toll-free enrollment number is **855.359.7354**.

How Health Plans Work

Preferred Provider Organization (PPO) Plans Non-Medicare

PPO plans give you the freedom to choose any doctor, whether or not he or she is a member of the PPO network, every time you need care. You do not need to select a Primary Care Physician (PCP) to coordinate your care and you can see a specialist any time you wish.

Anthem Blue Cross Plan – Non-Medicare

- Each time you need care, you can choose an in-network (PPO) or out-of-network (non-PPO) provider. Provider directories are available at the Anthem Blue Cross website www.anthem.com/ca.
- When you see a PPO provider, simply present your ID card at your appointment and pay a $10 office co-payment.
- The PPO plan does pay 100% of eligible health care expenses once the member reaches the $100 annual deductible, and the annual combined out-of-pocket maximum of $3,400 (100% of what is considered reasonable and customary; member responsible for the excess charges).
- When medication is prescribed, you must fill the prescription with a contracted retail pharmacy. You will pay the following:

  Retail Prescription
  Generic: $10 (30-day supply)
  Brand: $20 (30-day supply)

  Mail Order Prescription
  Generic: $10 (90-day supply)
  Brand: $20 (90-day supply)

Anthem Blue Cross High Deductible Health Plan (HDHP) is a plan offered through City of Glendale's health benefit program. This is a Non-Medicare Plan.

HDHPs have higher annual deductibles and out-of-pocket maximum limits than other types of program insurance plans including Fee for Service (FFS), Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO) health insurance plans. With an HDHP, the annual (high) deductible must be met before plan benefits are paid for services other than in-network preventive care services, which are fully covered before the deductible is met.

HDHPs also protect the HDHP participant against catastrophic out-of-pocket expenses for covered services. Once the HDHP participant's annual out-of-pocket expenses for services from in-network providers, (including deductibles, copayments and coinsurance) reaches the pre-determined catastrophic limit, the plan pays 100 percent of the allowable amount for the remainder of the calendar year.

How Health Plans Work (continued)

Anthem Blue Card Network PPO 80 / 60 Plan Non-Medicare (out-of-state plans)

- Each time you need care, you can choose an in-network (PPO) or out-of-network (non-PPO) provider. Provider directories are available at the Anthem Blue Cross website www.anthem.com/ca.
- When you see a PPO provider, simply present your ID card at your appointment and pay a $20 office co-payment.
- When your health care is not an office visit, your provider files the paperwork for your claim and you receive a bill in the mail for your deductible and/or coinsurance amount, usually 20% of the cost of most in-network covered services.
- When you see a non-PPO provider, you generally pay the out-of-network deductible, 40% of the cost for most covered services and the excess amount. In some instances, the provider might require payment up-front.
- The PPO plan does pay 100% of eligible health care expenses once the member reaches the annual out-of-pocket, which is In-Network: $2,000/Out-of-Network $4,000 (100% of what is considered reasonable and customary; member is still responsible for the excess charges).
- When medication is prescribed, you must fill the prescription with a contracted retail pharmacy. You will pay the following:

  Retail Prescription
  Generic: $10 (30-day supply)
  Brand: $20 (30-day supply)

  Mail Order Prescription
  Generic: $10 (90-day supply)
  Brand: $20 (90-day supply)

Click here to watch a video on Preferred Provider Organizations (PPO).

How Health Plans Work (continued)

HMO Plans

HMO plans provide a comprehensive array of services, including preventive care, at a minimal cost, but you must use only providers in the HMO plan network. A network includes doctors, hospitals, and other health care providers and facilities that have contracted with the HMO to provide care at lower fixed rates and/or discounted rates. HMOs do not generally pay benefits for care received outside the network, except in life/limb threatening emergency situations.

Anthem CaliforniaCare and Kaiser Permanente – Non-Medicare

- No deductibles
- Minimal copays for certain services (e.g., doctor's office visit - $10 copay)
- No charge for approved hospital stays
- No claim forms
- Covered preventive services such as annual physicals, well-baby and well-woman care and immunizations
- When medication is prescribed, you must fill the prescription at a contracted retail pharmacy. You will pay the following copay:

  Anthem CaliforniaCare
  Generic: $5 (30-day supply)
  Brand: $10 (30-day supply)

  Kaiser Permanente
  Generic: $5 (100-day supply)
  Brand: $10 (100-day supply)

Kaiser Permanente Deductible HMO - Non-Medicare

- Deductibles for specific services (see plan summary)
- **Minimal copays for certain services (e.g., doctor's office visit –** $20 copay)
- 20% coinsurance after plan deductible for approved hospital stays
- No claim forms
- Covered preventive services such as annual physicals, well-baby and well-woman care and immunizations

Anthem Blue Cross Senior Secure and Kaiser Senior Advantage – Medicare

- No deductibles
- Minimal copays for certain services (e.g., doctor's office visit - $10 copay)
- No charge for approved hospital stays
- No claim forms
- Covered preventive services such as annual physicals, well-baby and well-woman care and immunizations
- Covered vision benefits for routine exams and lens/frames benefits
- **Anthem Blue Cross Senior Secure:** covered dental care for preventive care and restorative services
- When medication is prescribed, you must fill the prescription at a contracted retail pharmacy. You will pay the following copay:

  Anthem Blue Cross Senior Secure
  $7 (30-day supply) Retail
  $15 (90-day supply) Mail-Order

  Kaiser Senior Advantage
  Generic: $10 (100-day supply)
  Brand: $25 (100-day supply)

Health Plan Decision Guidelines

It is important to review the Health Plans At-A-Glance comparison charts starting on page 10 for help in picking the right health plan.

How Do I Compare Health Plans?

After you review what benefits are available and decide what is important to you, comparing all the plans is the next step in making a decision. Many things should be considered. These include:

- Are the family doctors and specialists your family prefers part of the network? If not, are you willing to change doctors?
- If provider location is important to you, check to see if the network facilities are close to your home, your workplace or your child's school.
- How much money do you and your family typically spend on health care each year? How much are you willing to pay out-of-pocket for health care expenses? Remember that the PPO plan pays a higher percentage of expenses when you use network providers. HMOs require flat copays for most services, with no deductible, but you must use only HMO providers to have your expenses covered.
- What do you value more - having the lowest possible out-of-pocket costs (HMO options) or the flexibility to see any provider you wish (PPO options)?

Things to Consider

Here are some things to think about as you decide which health plan is right for you:

- Chronic health conditions or disabilities that you or family members have.
- If you or anyone in your family will need care for the elderly.
- Care for family members who travel a lot, attend college, or spend time at two homes.

Click here to watch a video on Health Maintenance Organizations (HMO).

Click here to watch a video on PPO vs HMO.

Medical Benefits – California PPO Plans

Non-Medicare

The following chart provides an overview of your health plan options through the City of Glendale. This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

Summary of Services	www.anthem.com/ca Anthem Blue Cross PPO 80 / 60 Plan	
	In-Network Benefits	Out-of-Network Benefits*
Maximum Lifetime Benefit	Unlimited	
Annual Deductible		
• Member	$200	$400
• Family	$400	$800
Annual Out-of-Pocket Maximum		
• Individual	$2,000	$4,000
• Family	$4,000	$8,000
	PPO MEMBER COPAY	**NON-PPO MEMBER COPAY**
Preventive Services		
• Office Visits	$20 / deductible waived	40%
• Visit to a Specialist	$20 / deductible waived	40%
• Annual Physicals	No copay	Not covered
• Self-Referral to GYN	Yes	Yes
• Mammograms	No copay	40%
• Well-Child Care	$25 / deductible waived	40% (limited to $20 / exam)
• Immunizations *(birth to age six)*	No copay	40% (limited to $12 / immunization)
• X-Ray and Laboratory	20%	40%
• Chiropractic Services	20%	40%
Emergency Service		
• Hospital Emergency Room *(copay waived if admitted)*	$100 copay + 20%	$100 copay + 20%
• Urgent Care	$20 copay	40%
• Hospital Inpatient Services	20%	40%
• Ambulance *(Air & Ground)*	20%	20%
Inpatient Hospital**		
• Inpatient Surgery	20%	40%
• Mental or Nervous Disorders	20%	40%
• Acute Alcoholism or Drug Dependence	20%	40%

* **Important Note:** Out-of-Network amounts/max you are responsible for may be higher due to no contract with Anthem, and providers could balance bill for anything Anthem does not pay.

** Pre-authorization required for facility-based care.

This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

California PPO Plans (continued)

Non-Medicare

Summary of Services	www.anthem.com/ca Anthem Blue Cross PPO 80 / 60 Plan	
	In-Network Benefits	Out-of-Network Benefits*
Outpatient Hospital**		
• Outpatient Surgery	No copay (deductible waived)	40% (limited to $350 / day)
• Mental or Nervous Disorders	20%	40%
• Acute Alcoholism or Drug Dependence	20%	40%
Maternity		
• Prenatal Care	$20	40%
• Postnatal Care	20%	40%
• Hospital Charges	20%	40%
Prescription		
• Generic	$10 (30 days)	50% up to $250 after deductible
• Brand	$20 (30 days)	50% up to $250 after deductible
• Mail Order Prescription Drugs	$10 / $20 (90 days)	Not Covered
• Oral Contraceptives	Yes	

* **Important Note:** Out-of-Network amounts/max you are responsible for may be higher due to no contract with Anthem, and providers could balance bill for anything Anthem does not pay.

** Pre-authorization required for facility-based care.

Hospital Quality Comparison

If you are interested in comparing hospitals in your area, visit www.healthcompare.com/futuriscare.

This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

Medical Benefits – Anthem Blue Cross High Deductible Health Plan (HDHP) Early Retirees (Non-Medicare) Only Plans

Anthem Blue Cross High Deductible Health Plan (HDHP)

Summary of Services	Anthem	
	HDHP $1500/$3000/$3200 20/40	
	In-Network	Out-of-Network*
• Annual Deductible/Individual	$1,500	$4,500
• Annual Deductible/Family	$3,000/member / $3,200 family	$4,500/member / $9,000 family
• Coinsurance	80%	60%
• Office Visit/Exam	80%	60%
• Outpatient Specialist Visit	80%	60%
• Annual Out-of-Pocket Limit/Individual	$3,500	$9,000
• Annual Out-of-Pocket Limit/Family	$3,500/member / $7,000 family	$9,000/member / $18,000 family
• Deductible Included in Out-of-Pocket Limits	Yes	Yes
Outpatient Services		
• Preventive Services		
– Most ACA-Mandated Preventive Care Services	100% (deductible waived)	60% (deductible waived)
• Diagnostic X-Ray and Lab Tests	80%	60%
Maternity Care		
• Pregnancy and Maternity Pre-Natal Care	80%	60%
Inpatient Hospital Services		
• Inpatient Hospitalization	80%	60% ($1k/day for non-emergency)
• Pre-Authorization of Services Required		
Surgical Services		
• Outpatient Facility Charge	80%	60% ($350 max/service)
Emergency Services		
– Emergency Room Copay *(Waived if Admitted)*	80%	80%
• Ambulance		
– Air & Ground	80%	80%
Urgent Care		
• Urgent Care Facility	80%	60%
Mental Health & Substance Abuse Benefits		
• Inpatient Care	80%	60% ($1k/day for non-emergency)
• Outpatient Care	80%	60%

* **Important Note:** Out-of-Network amounts/max you are responsible for may be higher due to no contract with Anthem, and providers could balance bill for anything Anthem does not pay

Click here to watch a video on High Deductible Health Plans (HDHP).

This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

Anthem Blue Cross High Deductible Health Plan (HDHP) Early Retirees (Non-Medicare) Only Plans (continued)

Anthem Blue Cross High Deductible Health Plan (HDHP) (continued)

Summary of Services	Anthem	
	HDHP $1500/$3000/$3200 20/40	
	In-Network	Out-of-Network*
Prescription Drug Benefits		
• Rx Deductible	Medical deductible applies	Medical deductible applies
• Rx Annual Out-of-Pocket Limit/Individual	Medical OOP limit applies	Medical OOP limit applies
• Rx Drug Annual Out-of-Pocket Limit/Family	Medical OOP limit applies	Medical OOP limit applies
• Generic	1a: $5 copay / 1b: $15 copay	40% coinsurance up to $250/rx
• Brand *(Formulary/Preferred)*	Tier 2: $40 copay	40% coinsurance up to $250/rx
• Brand *(Non-Formulary/Non-preferred)*	Tier 3: $60 copay	40% coinsurance up to $250/rx
• Typically Specialty *(Brand and Generic)*	Tier 4: 30% up to $250	40% coinsurance up to $250/rx
• Number of Days Supply	30 days	30 days
• Mail Order		
– Generic	1a: $12.50 copay / 1b: $37.50 copay	Not covered
– Brand *(Formulary/Preferred)*	Tier 2: $120 copay	Not covered
– Brand *(Non-Formulary/Non-preferred)*	Tier 3: $180 copay	Not covered
– Typically Specialty *(Brand and Generic)*	Tier 4: 30% up to $250	Not covered
– Number of Days Supply for Mail Order	90 days	N/A
Other Services and Supplies		
• Durable Medical Equipment	50%	50%
• Home Health Care	80% (100 days/year)	60% (100 days/year)
• Skilled Nursing or Extended Care Facility	80% (150 days/year)	60% (150 days/year)
• Hospice Care	80%	60%
• Chiropractic Services	80% (30 visits/year)	60% (30 visits/year)
• Acupuncture	80% (20 visits/year)	60% (20 visits/year)
Outpatient Rehabilitative Therapy Services		
• Physical & Occupational	80% (40 days/year)	60% (40 days/year)
• Speech	80% (40 days/year)	60% (40 days/year)

* **Important Note:** Out-of-Network amounts/max you are responsible for may be higher due to no contract with Anthem, and providers could balance bill for anything Anthem does not pay

Click here to watch a video on HDHP vs PPO.

This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

Anthem Blue Cross High Deductible Health Plan (HDHP) Early Retirees (Non-Medicare) Only Plans (continued)

A high deductible health plan (HDHP) is offered through City of Glendale's health benefit program.

HDHPs have higher annual deductibles and out-of-pocket maximum limits than other types of program insurance plans including Fee for Service (FFS), Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO) health insurance plans. With an HDHP, the annual (high) deductible must be met before plan benefits are paid for services other than in-network preventive care services, which are fully covered before the deductible is met.

HDHPs also protect the HDHP participant against catastrophic out-of-pocket expenses for covered services. Once the HDHP participant's annual out-of-pocket expenses for services from in-network providers, (including deductibles, copayments and coinsurance) reaches the pre-determined catastrophic limit, the plan pays 100 percent of the allowable amount for the remainder of the calendar year.

QUESTIONS AND ANSWERS:

Q: Does the deductible accumulate from January through December or June through May?

A: The deductible resets to zero every calendar year

Q: How does the deductible work?

A: The deductible is the amount you pay for covered services, each plan year, before Anthem starts paying. If you cover any other members of your family on your plan, you are subject to the family deductible. All members of the family work together, to satisfy the family deductible.

Q: What is coinsurance and when do I pay it?

A: Coinsurance is the percentage of the cost of covered services you'll pay after you've reached your deductible. Once the deductible is met, Anthem will pay 80% of most covered services and you will be responsible for 20% of covered services rendered by a contracted provider.

Q: How do I pay for prescriptions?

A: You will pay the full cost of prescription drugs until your deductible is met. Then, you will pay the applicable co-pays for brand and generic drugs and coinsurance for specialty drugs - until your out-of-pocket maximum is met.

Q: Please explain the Out-of-Pocket Maximum (OPM)

A: The OPM is the maximum amount you'll pay in a plan year for most services covered under your plan. Once the OPM is met, Anthem will pay 100% for most covered services for the rest of the plan year. Your deductible, prescription copayments and coinsurance payments, all apply towards your OPM.

With the HDHP, if you cover any other members of your family on your plan, you are subject to the family OPM. All members of the family work together, to satisfy the family OPM.

Q: How much do I pay for Primary Care Physician (PCP) and Specialty Office Visits?

A: You will pay the full cost of office visits and any tests or procedures received during the visit until your deductible is met. Once your deductible is met, you pay for covered services at your coinsurance.

Q: Do I pay for my lab and imaging?

A: You will pay the full cost of lab work and any imaging, such as x-rays, CT/PET scans and MRIs, until your deductible is met, and then, you'll pay your coinsurance for these services.

Q: What about After-hours care & Emergency Room care?

A: You will pay the full cost of after-hours and emergency care until your deductible is met.

California HMO Plans

Non-Medicare

Summary of Services	www.anthem.com/ca	www.kp.org	
	Anthem Blue Cross CaliforniaCare HMO	Kaiser Permanente Traditional HMO	Kaiser Permanente Deductible HMO (Early Retirees Only)
	In-Network Benefits Only	In-Network Benefits Only	In-Network Benefits Only
Maximum Lifetime Benefit	Unlimited	Unlimited	Unlimited
Annual Deductible			
• Member	N/A	N/A	$1,000
• Family	N/A	N/A	$2,000
Annual Out-of-Pocket Maximum			
• Member	$500	$1,500	$3,000
• Family	$1,500	$3,000	$6,000
	MEMBER COPAY	**MEMBER COPAY**	**MEMBER COPAY**
Preventive Services			
• Office Visits	$10 copay	$10 copay	$20 copay
• Visit to a Specialist	$10 copay	$10 copay	$20 copay
• Annual Physicals	No copay	No copay	No copay
• Self-Referral to GYN	Yes	Yes	Yes
• Mammograms	No copay	No copay	No copay
• Well-Child Care	No copay (birth through age 6)	No copay	No copay (birth to age 23 months)
• Immunizations	No copay (birth through age 6)	No copay	No copay
• X-Ray and Laboratory	No copay	No copay	No copay
• Chiropractic Services	No copay (60 consecutive days)	$10 copay (30 visits)	$10 (30 visits)
Emergency Service			
• Hospital Emergency Room *(waived if admitted)*	$25 copay / visit	$50 copay/visit	20%
• Urgent Care	$10 copay	$10 copay	$20 copay
• Hospital Inpatient Services	No copay	No copay	20%
• Ambulance *(Air & Ground)*	No copay	$50 copay/trip	$150 copay/trip

This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

California HMO Plans (continued)

Non-Medicare

Summary of Services	www.anthem.com/ca	www.kp.org	
	Anthem Blue Cross CaliforniaCare HMO	Kaiser Permanente Traditional HMO	Kaiser Permanente Deductible HMO (Early Retirees Only)
	In-Network Benefits Only	In-Network Benefits Only	In-Network Benefits Only
	MEMBER COPAY	MEMBER COPAY	MEMBER COPAY
Inpatient Hospital *			
• Inpatient Surgery	No copay	No copay	20%
• Mental or Nervous Disorders	No copay	No copay	20%
• Acute Alcoholism or Drug Dependence	No copay	No copay	20%
Outpatient Hospital			
• Outpatient Surgery	No copay	$10 copay/procedure	20%
• Mental or Nervous Disorders	$10 copay/visit	$10 copay/ind. $5 copay/group	$20 copay/visit (Ind.) $10 copay/visit (Group)
• Acute Alcoholism or Drug Dependence	$10 copay/visit	$10 copay/ind. $5 copay/group	$20 copay/visit (Ind.) $5 copay/visit (Group)
Maternity			
• Prenatal Care	$10 copay	$5 copay	No copay
• Postnatal Care	$10 copay	$10 copay	No copay
• Hospital Charges	No copay	No copay	20%
Prescription			
• Generic	$5 copay (30 days)	$5 copay (100 days)	$10 copay (30 days)
• Brand *(Preferred)*	$10 copay (30 days)	$10 copay (100 days)	$30 copay (30 days)
• Brand *(Non-Preferred)*	N/A	N/A	N/A
• Mail Order Prescription Drugs	$5 copay / $20 copay (90 days)	$5 copay / $10 copay (100 days)	$20 copay / $60 copay (100 days)
• Oral Contraceptives	Yes	Yes	Yes

* Pre-authorization required for facility-based care

This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

California HMO Plans (continued)

Medicare

The following chart provides an overview of your health plan options through the City of Glendale.

Summary of Services	www.anthem.com/ca Anthem Blue Cross Senior Secure HMO In-Network Benefits Only	www.kp.org Kaiser Senior Advantage HMO In-Network Benefits Only
Maximum Lifetime Benefit	Unlimited	Unlimited
Annual Out-of-Pocket Maximum		
• Member	N/A	$1,500
• Family	N/A	$3,000
	MEMBER COPAY	
Preventive Services		
• Office Visits	No copay	$10
• Visit to a Specialist	No copay	$10
• Annual Physicals	No copay	No copay
• Mammograms	No copay	No copay
• Vision Exams and Frames	$10 (1 exam / year) ($75 allowance / 24 months)	$10 ($150 allowance / 24 months)
• Hearing Exams	No copay (1 exam / year)	$10
• X-Ray and Laboratory	No copay	No copay
• Chiropractic Services	$5 (12 visits / cal year)	Not covered
• Dental Coverage	Yes	Not covered
Emergency Service		
• Hospital Emergency Room *(waived if admitted)*	$20 / visit	$50 / visit
• Urgent Care	No copay	$10 copay
• Hospital Inpatient Services	No copay	$200 / admission
• Ambulance *(Air & Ground)*	No copay	$50 / trip
Inpatient Hospital		
• Inpatient Surgery	No copay	$200 / admission
• Mental or Nervous Disorders	No copay	$200 / admission
• Acute Alcoholism or Drug Dependence	No copay	$200 / admission
Outpatient Hospital		
• Outpatient Surgery	No copay	$10 / procedure
• Mental or Nervous Disorders	No copay	$10 / individual; $5 / group
• Acute Alcoholism or Drug Dependence	No copay	$10 / individual; $5 / group
Prescription		
• Generic	$7 (30 days)	$10 (100 days)
• Brand	$7 (30 days)	$25 (100 days)
• Mail Order Prescription Drugs	$15 (90 days)	$10 / $25 (100 days)

This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

Medical Benefits – Medicare Advantage (MAPD Plan)

Medicare Advantage

The following chart provides an overview of your health plan options through the City of Glendale. This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

Summary of Services	www.anthem.com/ca Anthem Blue Cross Medicare Advantage Plan	
	In-Network Benefits	Out-of-Network Benefits
Maximum Lifetime Benefit	Unlimited	
Annual Deductible		
• Member	$100	
Annual Out-of-Pocket Maximum		
• Combined in and out-of-network	$3,400	
	PPO MEMBER COPAY	**NON-PPO MEMBER COPAY**
Preventive Services		
• Office Visits	$10 copay/deductible applies	
• Visit to a Specialist	$25 copay/deductible applies	
• Preventive Care and Screenings	Covered at 100%	
• Bone mass measurement	$0 copay	
• Colorectal screening	$0 copay	
• Cardiovascular screening	$0 copay	
• Diabetes screening	$0 copay	
• Mammograms	$0 copay	
• Prostrate screening	$0 copay	
• Physical Exam	$0 copay	
• Annual Wellness visit	$0 copay	
• Chiropractic Services	$20 copay /deductible applies	
Emergency Service		
• Emergency outpatient care *(waived if admitted within 72 hours)*	$75 copay/deductible does not apply	
• Urgent Care	$25 copay/deductible does not apply	
• Ambulance *(provider must get approval if not emergency)*	$50 copay (one way trip) (Deductible does not apply)	

* Pre-authorization required for facility-based care.

This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

Medicare Advantage (MAPD Plan)

Medicare Advantage

Summary of Services	www.anthem.com/ca Anthem Blue Cross Medicare Advantage Plan	
	In-Network Benefits	Out-of-Network Benefits
Inpatient Hospital*		
• Inpatient Surgery	$300 copay/admit (Deductible applies)	
• Mental or Nervous Disorders	$300 copay/admit (Deductible applies)	
• Acute Alcoholism or Drug Dependence	$300 copay/admit (Deductible applies)	
Outpatient Hospital*		
• Outpatient Surgery	$100 copay/deductible applies	
• Mental or Nervous Disorders	$25 copay/deductible applies	
• Acute Alcoholism or Drug Dependence	$25 copay/deductible applies	
Prescription		
• Generic	$10 (30 days)	Not covered
• Brand	$20 (30 days)	Not covered
• Mail Order Prescription Drugs	$10 / $20 (90 days)	Not Covered
• Oral Contraceptives	Yes	

* Pre-authorization required for facility-based care.

Hospital Quality Comparison

If you are interested in comparing hospitals in your area, visit www.healthcompare.com/futuriscare.

This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

Out-of-State Plans

Non-Medicare

The following chart provides an overview of your health plan options through the City of Glendale.

Summary of Services	www.anthem.com/ca Anthem Blue Cross Blue Card Network 80 / 60 Plan Non-Medicare	
	In-Network Benefits	Out-of-Network Benefits
Maximum Lifetime Benefit	Unlimited	
Annual Deductible		
• Member	$200	$400
• Family	$400	$800
Annual Out-of-Pocket Maximum	$2,000	$4,000
	PPO MEMBER COPAY	**NON-PPO MEMBER COPAY**
• Preventive Services	No copay	40%
• Office Visits	$20 / deductible waived	40%
• Visit to a Specialist	$20 / deductible waived	40%
• Annual Physicals	No copay	Not covered
• Mammograms	No copay	40%
• Vision Exams and Frames	Not covered	Not covered
• X-Ray and Laboratory	20%	20%
• Chiropractic Services	20%	40% (limit $25 / visit)
• Dental Coverage	Not covered	Not covered
Emergency Service		
• Hospital Emergency Room	20%/deductible waived if admitted	20%/deductible waived if admitted
• Urgent Care	$20 copay	40%
• Hospital Inpatient Services	20%	40%
• Ambulance	20%	20%

This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

Out-of-State Plans (continued)

Non-Medicare

Summary of Services	www.anthem.com/ca Anthem Blue Cross Blue Card Network 80 / 60 Plan Non-Medicare	
	In-Network Benefits	Out-of-Network Benefits
	PPO MEMBER COPAY	NON-PPO MEMBER COPAY
Inpatient Hospital*		
• Inpatient Surgery	20%	40%
• Mental or Nervous Disorders	20%	40%
• Acute Alcoholism or Drug Dependence	20%	40%
Outpatient Hospital		
• Outpatient Surgery	No copay & deductible waived	40%
• Mental or Nervous Disorders	20%	40%
• Acute Alcoholism or Drug Dependence	20%	40%
Prescription		
• Generic	$10 (30-day supply)	50% up to $250 after deductible
• Brand	$20 (30-day supply)	50% up to $250 after deductible
• Mail Order Prescription Drugs	$10/20 (90-day supply)	Not covered
• Limits in a Calendar Year	None	

* Pre-authorization required for facility-based care.

This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

Out-of-State Plans (continued)

Anthem Blue Cross High Deductible Health Plan (HDHP)

Summary of Services	Anthem	
	HDHP $1500/$3000/$3200 20/40	
	In-Network	Out-of-Network*
• Annual Deductible/Individual	$1,500	$4,500
• Annual Deductible/Family	$3,000/member / $3,200 family	$4,500/member / $9,000 family
• Coinsurance	80%	60%
• Office Visit/Exam	80%	60%
• Outpatient Specialist Visit	80%	60%
• Annual Out-of-Pocket Limit/Individual	$3,000	$9,000
• Annual Out-of-Pocket Limit/Family	$3,500/member / $7,000 family	$9,000/member / $18,000 family
• Deductible Included in Out-of-Pocket Limits	Yes	Yes
Outpatient Services		
• Preventive Services		
– Most ACA-Mandated Preventive Care Services	100% (deductible waived)	60% (deductible waived)
• Diagnostic X-Ray and Lab Tests	80%	60%
Maternity Care		
• Pregnancy and Maternity Pre-Natal Care	80%	60%
Inpatient Hospital Services		
• Inpatient Hospitalization	80%	60% ($1k/day for non-emergency)
• Pre-Authorization of Services Required		
Surgical Services		
• Outpatient Facility Charge	80%	60% ($350 max/service)
Emergency Services		
– Emergency Room Copay *(Waived if Admitted)*	80%	80%
• Ambulance		
– Air & Ground	80%	80%
Urgent Care		
• Urgent Care Facility	80%	60%
Mental Health & Substance Abuse Benefits		
• Inpatient Care	80%	60% ($1k/day for non-emergency)
• Outpatient Care	80%	60%

* **Important Note:** Out-of-Network amounts/max you are responsible for may be higher due to no contract with Anthem, and providers could balance bill for anything Anthem does not pay

Click here to watch a video on High Deductible Health Plans (HDHP).

This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

Out-of-State Plans (continued)

Anthem Blue Cross High Deductible Health Plan (HDHP) (continued)

Summary of Services	Anthem	
	HDHP $1500/$3000/$3200 20/40	
	In-Network	Out-of-Network*
Prescription Drug Benefits		
• Rx Deductible	Medical deductible applies	Medical deductible applies
• Rx Annual Out-of-Pocket Limit/Individual	Medical OOP limit applies	Medical OOP limit applies
• Rx Drug Annual Out-of-Pocket Limit/Family	Medical OOP limit applies	Medical OOP limit applies
• Generic	1a: $5 copay / 1b: $15 copay	40% coinsurance up to $250/rx
• Brand *(Formulary/Preferred)*	Tier 2: $40 copay	40% coinsurance up to $250/rx
• Brand *(Non-Formulary/Non-preferred)*	Tier 3: $60 copay	40% coinsurance up to $250/rx
• Typically Specialty *(Brand and Generic)*	Tier 4: 30% up to $250	40% coinsurance up to $250/rx
• Number of Days Supply	30 days	30 days
• Mail Order		
– Generic	1a: $12.50 copay / 1b: $37.50 copay	Not covered
– Brand *(Formulary/Preferred)*	Tier 2: $120 copay	Not covered
– Brand *(Non-Formulary/Non-preferred)*	Tier 3: $180 copay	Not covered
– Typically Specialty *(Brand and Generic)*	Tier 4: 30% up to $250	Not covered
– Number of Days Supply for Mail Order	90 days	N/A
Other Services and Supplies		
• Durable Medical Equipment	50%	50%
• Home Health Care	80% (100 days/year)	60% (100 days/year)
• Skilled Nursing or Extended Care Facility	80% (150 days/year)	60% (150 days/year)
• Hospice Care	80%	60%
• Chiropractic Services	80% (30 visits/year)	60% (30 visits/year)
• Acupuncture	80% (20 visits/year)	60% (20 visits/year)
Outpatient Rehabilitative Therapy Services		
• Physical & Occupational	80% (40 days/year)	60% (40 days/year)
• Speech	80% (40 days/year)	60% (40 days/year)

* **Important Note:** Out-of-Network amounts/max you are responsible for may be higher due to no contract with Anthem, and providers could balance bill for anything Anthem does not pay

Click here to watch a video on HDHP vs PPO.

This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

Out-of-State Plans (continued)

Medicare Advantage

Summary of Services	www.anthem.com/ca Anthem Blue Cross Medicare Advantage Plan	
	In-Network Benefits	Out-of-Network Benefits
Maximum Lifetime Benefit	Unlimited	
Annual Deductible		
• Member	$100	
Annual Out-of-Pocket Maximum		
• Combined in and out-of-network	$3,400	
	PPO MEMBER COPAY	**NON-PPO MEMBER COPAY**
Preventive Services		
• Office Visits	$10 copay/deductible applies	
• Visit to a Specialist	$25 copay/deductible applies	
• Preventive Care and Screenings	Covered at 100%	
• Bone mass measurement	$0 copay	
• Colorectal screening	$0 copay	
• Cardiovascular screening	$0 copay	
• Diabetes screening	$0 copay	
• Mammograms	$0 copay	
• Prostrate screening	$0 copay	
• Physical Exam	$0 copay	
• Annual Wellness visit	$0 copay	
• Chiropractic Services	$20 copay /deductible applies	
Emergency Service		
• Emergency outpatient care *(waived if admitted within 72 hours)*	$75 copay/deductible does not apply	
• Urgent Care	$25 copay/deductible does not apply	
• Ambulance *(provider must get approval if not emergency)*	$50 copay (one way trip) (Deductible does not apply)	

* Pre-authorization required for facility-based care.

This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

Out-of-State Plans (continued)

Medicare Advantage

Summary of Services	www.anthem.com/ca Anthem Blue Cross Medicare Advantage Plan	
	In-Network Benefits	Out-of-Network Benefits
Inpatient Hospital*		
• Inpatient Surgery	$300 copay/admit (Deductible applies)	
• Mental or Nervous Disorders	$300 copay/admit (Deductible applies)	
• Acute Alcoholism or Drug Dependence	$300 copay/admit (Deductible applies)	
Outpatient Hospital*		
• Outpatient Surgery	$100 copay/deductible applies	
• Mental or Nervous Disorders	$25 copay/deductible applies	
• Acute Alcoholism or Drug Dependence	$25 copay/deductible applies	
Prescription		
• Generic	$10 (30 days)	Not covered
• Brand	$20 (30 days)	Not covered
• Mail Order Prescription Drugs	$10 / $20 (90 days)	Not Covered
• Oral Contraceptives	Yes	

* Pre-authorization required for facility-based care.

Hospital Quality Comparison

If you are interested in comparing hospitals in your area, visit www.healthcompare.com/futuriscare.

This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

Dental

The City offers three dental care plans for qualified retirees, two of which provide you with more flexibility in selecting dentists (PPO), while the other requires you to choose your dentist from a list (DMO).

The dental care plan helps pay for preventive and restorative dental services for you and your dependents. The plan has three options, all of which are administered by Guardian.

1. **High Option PPO –** can only elect if enrolled in Anthem PPO plan or waived medical coverage.
2. Buy-Up PPO
3. MDC-G90 DMO

High Option PPO & Buy-Up PPO

The High Option and Buy-Up are standard PPO programs in which members have the freedom to choose any dentist. The program pays a percentage for covered services. You can search for contracted in-network providers on the Guardian website at www.guardiananytime.com under the Preferred Network

MDC-G90 DMO

The MDC-G90 DMO is a dental program that provides you and your family with quality dental benefits at an affordable cost. The MDC-G90 DMO program is designed to encourage you and your family to visit the dentist regularly to maintain your dental health. To receive your benefits, you must select a primary care network dentist when you enroll. The network consists of private practice dental offices that have been carefully screened for quality.

Note

In order to be eligible for the High Option PPO Plan, retirees must be enrolled in the Anthem Blue Cross PPO health plan or waive medical coverage.

This is only applicable to retirees who qualify per their Association's Memorandum of Understanding (MOU) at retirement.

Dental (continued)

The following chart provides an overview of your dental plan options through the City of Glendale.

Plan Benefits	www.guardianantytime.com				
	High Option PPO *Only Available if Enrolled in Anthem Blue Cross Prudent Buyer (PPO) Medical Plan or waived medical coverage*		**Buy-Up PPO**		**MDC-G90 DMO**
	In-Network	**Out-of-Network***	**In-Network**	**Out-of-Network***	**In-Network Only**
Annual Maximum Benefit	$1,500	$1,000	$1,000	$1,000	Unlimited
Annual Deductible: Individual *(3 individual deductibles / family)*	$50 Deductible waived for Preventive Services			$50	N/A
	PPO % PAID	**NON-PPO % PAID**	**PPO % PAID**	**NON-PPO % PAID**	**IN-NETWORK COPAY**
Preventive Services					
• Oral Exam	100%	100%	80%	80%	No charge
• Teeth Cleaning	100%	100%	80%	80%	No charge
• X-Rays	100%	100%	80%	80%	No charge
Basic Services					
• Fillings	90%	80%	80%	60%	No charge
• Extractions	90%	80%	80%	60%	$0 – $40
• Endodontic Services / Root Canal Therapy	90%	80%	80%	60%	$0 – $90
• Periodontal Services	90%	80%	80%	60%	$0 – $95
• Oral Surgery	90%	80%	80%	60%	$0 – $55
• General Anesthesia *(Surgical Procedures Only)*	90%	80%	80%	60%	Not covered
Major Services					
• Crowns	60%	50%	50%	40%	$90
• Dentures *(Full / Partial)*	60%	50%	50%	40%	$110 – $130
• Bridges	60%	50%	50%	40%	$110 – $130
Orthodontic Services					
• Children	60% ($1,500 lifetime max)	50% ($1,500 lifetime max)	N/A		$1,975
• Adults	N/A	N/A	N/A		$2,175

* **Important Note:** Out-of-Network amounts/max you are responsible for may be higher due to no contract with Anthem, and providers could balance bill for anything Anthem does not pay.

This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.

Vision

As a VSP member, you have access to care from great eye doctors, quality eyewear, and the affordability you deserve, all at low out-of-pocket costs.

You'll like what you see with VSP.

- **Value and Savings:** You'll enjoy more value and low out-of-pocket costs.
- **High Quality Vision Care:** You'll get great care from a VSP network doctor, including a WellVision Exam® — a comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers:** The decision is yours to make — with the largest national network of private-practice doctors, plus participating retail chains, it's easy to find the in-network doctor who's right for you.
- **Great Eyewear:** It's easy to find the perfect frame at a price that fits your budget.

1. Brands/Promotion subject to change.
2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.

Using Your VSP Benefit is Easy

- Create an account at vsp.com. Once your plan is effective, review your benefit information.
- Find an eye doctor who's right for you. Visit vsp.com or call 800.877.7195.
- At your appointment, tell them you have VSP. There's no ID card necessary. If you'd like a card as a reference, you can print one on vsp.com.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe, CALVIN KLEIN, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.[1] Visit vsp.com to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.[2] Prefer to shop online? Check out all of the brands at eyeconic.com®, VSP's preferred online eyewear store.

Visit www.vsp.com or call 800.877.7195 for more details on your vision coverage and exclusive savings and promotions for VSP members.

Vision (continued)

Good vision is an important component to your overall health. Retirees are now eligible to purchase voluntary vision coverage through VSP.

Vision Service Plan (VSP) Eligibility

The City provides the Vision Service Plan for employees and their eligible dependents at no cost. The plan pays benefits and offers discounts for most vision care expenses you incur while covered by the plan, subject to the maximum amounts shown below.

Vision Plan At-a-Glance – Your Coverage with a VSP Provider

Benefit	Description	Copay	Frequency
WellVision Exam	Focuses on your eyes and overall wellness	$10 for exam and glasses	Every 12 months
Prescription Glasses			
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 Costco® frame allowance	Combined with exam	Every 12 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Combined with exam	Every 12 months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses Average savings of 20-25% on other lens enhancements	$55 $95 - $105 $150 - $175	Every 12 months
Contacts *(instead of glasses)*	• $130 allowance for contacts and contact lens exam *(fitting and evaluation)*	$0	Every 12 months
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

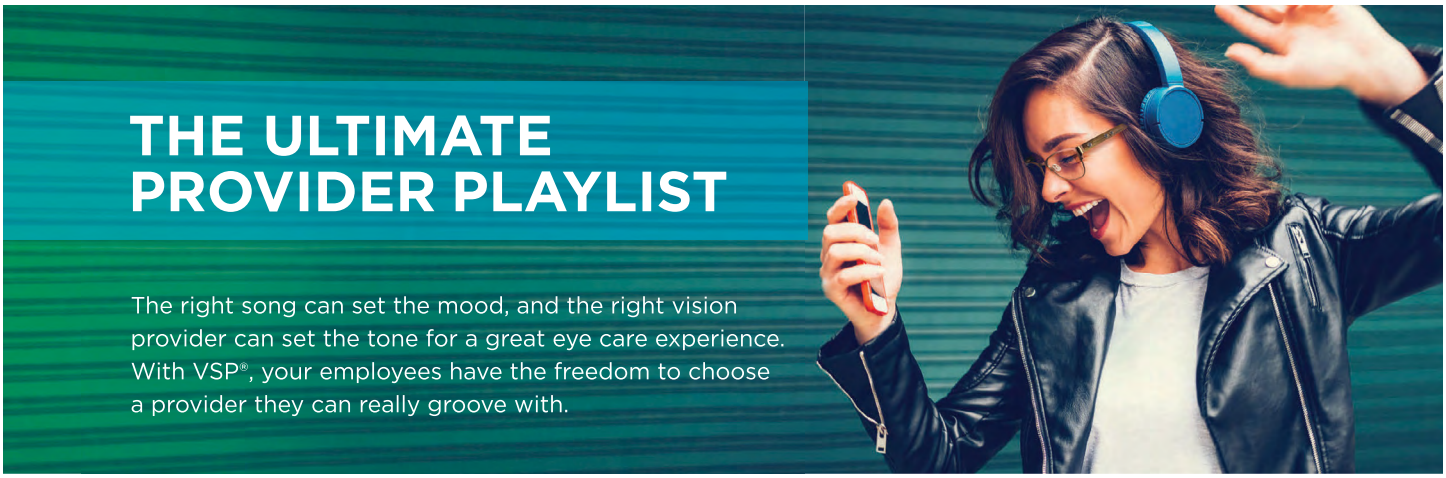
Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

- **Exam:** up to $45
- **Frame:** up to $70
- **Single Vision Lenses:** up to $30
- **Lined Bifocal Lenses:** up to $50
- **Lined Trifocal Lenses:** up to $65
- **Progressive Lenses:** up to $50
- **Contacts:** up to $105

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Vision (continued)



MORE CHOICES. MORE FREEDOM.

VSP NETWORK PROVIDERS **84K** ACCESS POINTS

VSP® Vision Care

When it comes to choices, VSP has your employees and their eyes covered with a huge network of independent doctors, popular retailers, and an online option.

Independent Doctors

91% offer early morning, evening, and weekend appointments.

24-hour access to emergency care.

Eye Health Management Program®.

VSP Premier Program gives members the most out of their eye care experience at one location.

VSP PREMIER PROGRAM

Retail Chains

For employees who prefer their favorite retailer, our network includes tons of participating retail chains, including:

COSTCO OPTICAL · OPTYX · PEARLE VISION · Visionworks · COHEN'S Fashion Optical

Effortless Out-of-network Shopping

Buy Online, Anytime! Want even more options? You got it! Your employees can shop the latest designer glasses and name brand contacts online at Eyeconic.com®.

They can also choose any provider they wish. Saying, "I have VSP," is all it takes to shop out-of-network. We'll do the rest!

eyeconic®

Enjoy the sweet song of employee satisfaction with true freedom of choice from VSP.

Health and Wellness

Are you wondering how you can start improving your wellness today? In addition to taking advantage of the City's resources, you can also take steps to get the most of your medical coverage. This can even help you save money on health care costs! Start following these tips today.

Tips for Using Your Benefits Wisely

Use Preventive Care Benefits

Health checks, flu shots, and a variety of other discounted and free services are provided by the City and your medical plans. Preventive care addresses your wellness needs today, and reduces your risk for future health problems and unexpected costs. Remember, if you're enrolled in an Anthem PPO, CaliforniaCare or Kaiser plan, preventive care is 100% covered when you are using in-network providers!

Visit an Urgent Care Facility Instead of the ER

If you're experiencing a true, life-threatening emergency, don't think twice about going to the emergency room. If your condition is not life-threatening, you'll pay less and experience less waiting time by choosing an urgent or after-hours care center.

Choose Generic Drugs

A generic drug is often as effective as its brand-name counterpart and costs less to produce. These savings are passed on to you, and your cost will be less when you ask for the generic equivalent of your prescription drug.

Use Anthem's Online Tools

Visit www.anthem.com and click the "Member Log In" to use Anthem Navigator. Take advantage of their Wellness Tool Kit which offers the following:

- **Health Assessment:** Learn your overall health status by completing MyHealth Assessment.
- **Health Record:** Manage your health information with the Health Record. Your claims history can be added to help track your health.
- **Health Assistant:** Take action towards your health goals with a holistic approach to behavior change. It allows you to select goals, track your progress, gain key insights, and create a plan that works for you.
- **Symptom Checker:** Interactive WebMD's Symptom Checker. You can determine what you can do about your symptoms.
- **Health Trackers:** Track your personal health with 24 specific health measurements tools. Identify trends and stay on track to a healthier you!
- **Quizzes & Calculators:** BMI, calorie, metabolism, rate your energy, target heart rate, are you depressed, heart disease quiz, child immunizations, health refrigerator, keep your kids active and drug interaction checker.

Health and Wellness (continued)

Use Kaiser's Online Tools

You may be able to save yourself an office visit! Visit www.kp.org to get answers to your health questions from your own doctor, or take a self-guided health living course. The health and wellness toolkit on Kaiser's website offers their members the following:

- **Conditions and Diseases:** Not feeling like yourself? Learn about common conditions in Kaiser's health guides, or use their symptom checker, or explore their health encyclopedia.
- **Programs and Classes:** Get online programs, special rates, and classes to help you live healthier.
- **Call a Coach:** They offer trained wellness coaches to give you free, personalized guidance by phone. Get help to lose weight, eat healthier, quit smoking, and more.
- **Live Healthy:** Get physician-reviewed health information and online tools.
- **Drugs and Natural Medicines:** Get the facts on the prescriptions in your medicine chest and the vitamins in your kitchen with their drug and natural medicine resources.

Patient Advocacy Tools

Quality health care can be defined as the extent to which patients get the care they need in a manner that most effectively protects or restores their health. Choosing a high-quality health plan and a high quality doctor plays a significant role in determining whether a patient will receive high quality care. Here are some online tools and information to help you make informed choices:

- **The Leapfrog Group:** Compare hospitals at www.leapfroggroup.org
- **Vitals.com:** Find a doctor by name, specialty, or condition at www.vitals.com
- **Medicare.Gov:** Compare physicians at www.medicare.gov/physiciancompare

Retired City Guidelines

Medical Guidelines and Provisions

- Active employees upon retirement will be eligible to participate in the Retirement Medical Programs in which they belong to at the time of retirement.
- Retired employee plan benefits are similar to those for active employees. In addition, retired employees have the option of electing Medical Risk Plans at age 65 and older, through Futuris Care / Medicare Exchange.
- A retired City employee and/or qualified dependent who is eligible for Medicare coverage by reason of age or disability must be enrolled in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to enroll or remain in the City's Retirement Medical Programs.
- Effective June, 1, 2011, the insurance carriers have implemented penalty rates to retirees who are eligible for Medicare, but have not enrolled in Part A (Hospital Insurance) and Part B (Medical Insurance) within their eligibility enrollment period. The penalty rates go into effect the 1st of the month of the retiree's 65th birthday.
- If a retired City employee and/or qualified dependent enroll in Medicare Part A (Hospital Insurance) and do not qualify for Part A for free, the City will reimburse the cost of their Medicare Part A (Hospital Insurance) premium.
- Retired City employees eligible for Medicare Part A reimbursement must submit their Medicare Part A invoice on a monthly basis. There will be no retroactive reimbursements.
- Once a retired City employee and/or qualified dependent becomes eligible for Medicare, the City's Benefits Section and FuturisCare Retiree Services will provide the retiree and/or qualified dependent information and correspondence three months prior to their 65th birthday regarding Medicare enrollment and information to assist in the enrollment process for their new secondary coverage.
- Retired employees may add new dependents after retirement (consistent with the plan terms and contracts).
- The spouse or domestic partner of a deceased retired City employee may remain on the insurance plan after the death of the retired employee subject to plan restrictions and requirements.
- Retired City employees or dependents who separate from the City's Retirement Medical Program for any reason, including but not limited to non-payment of premiums, relinquish their right to any future participation and shall not be eligible to rejoin the plan at a later date. (This does not apply to retirees that were on the retiree medical plan as of August 1, 2015, unless they were removed due to non-payment of premiums.)
- Retired City employees who were actively enrolled on the retiree medical plan as of August 1, 2015, and have since left the plan, may elect to re-enroll in a City medical plan. Retirees choosing to return to a City plan will only be able to do so during an authorized open enrollment period and will pay the unblended medical insurance premium rate. Retirees choosing to return must provide proof of medical insurance coverage immediately prior to their requested return. Retirees who were removed due to non-payment of premiums are not eligible to return.
- Retired City employees who are married to one another have specific eligibility requirements. When one of those current or retired employees is in a dependent status on the other's insurance, the dependent employee retains the right to be insured independently as a single on the plan provided that there has been no break in coverage, and their status conforms to another plan and City's policy requirements.

Retired City Guidelines (continued)

Dental and Vision Guidelines and Provisions

- Dental and Vision coverage may be continued with the City with the retired employee responsible for the payment of the full premium.
- Retired employees may add new dependents after the retirement (consistent with the plan terms and contracts) provided they have not previously been a dependent during the employees' retirement.
- The spouse or domestic partner of a deceased retired City employee may remain on the insurance plan after the death of the retired employee (subject to plan restrictions and requirements).
- Retired City employees or dependents who separate from the City's Retirement Dental and Vision Program for any reason, including but not limited to non-payment of premiums, relinquish their right to any future participation and shall not be eligible to rejoin the plan at a later date.

Life Guidelines and Provisions

- Retired Executive, Management and Mid-Management employees who have Life Insurance coverage through the City may continue 1x annual salary life coverage to the maximum limit of $100,000 at retirement until age 65.
- Retired City employees who separate from the City's Retirement Life Program for any reason, including but not limited to non-payment of premiums, relinquish their right to any future participation and shall not be eligible to rejoin the plan at a later date.

IMPORTANT

Failure to pay insurance premiums as required will result in **TERMINATION** from the City's insurance plan(s).

Retiree Billing Services

The City of Glendale utilizes PayFlex as our TPA (third party administrator) to manage the City's Retiree Billing Services. As the Billing Administrator for the City, PayFlex handles all aspects of retiree administration including:

- Collection of premium payments
- Customer Service assistance
- Distribution of required Retiree notices

In directing your monthly payments to PayFlex, invoices will be mailed to you. The invoice will provide the cost of your benefit election, the date payment is due, and the mailing address where payment should be directed.

If you choose to set up automatic bill pay with your bank, use the address below. Please indicate Retiree Billing Payments - City of Glendale 0007070 in the description or reason to pay to identify your payment.

PayFlex Systems USA, Inc.
Benefit Billing Department
P.O. Box 953374
St Louis, MO 63195-3374

If you have any questions, please contact PayFlex **(800.359.3921)** for customer service. You can access your account online at www.payflex.com.

PayFlex is unable to make any changes to your benefits or contact information with out notification from the City. If you need to make any changes, please contact the City at 818.548.2160.

IMPORTANT

You must notify the City of Glendale when terminating coverage.

City of Glendale
Benefits Division
613 E. Broadway, Room 100
Glendale, CA 91206

818.548.2160

benefits@glendaleca.gov

Health Care Reform Update

As you know, the Affordable Care Act (ACA, also known as "Health Care Reform") was passed in 2010 and is intended to extend access to medical coverage to nearly everyone in the United States, eliminate restrictions on key benefits, and help control the country's rising health costs.

Effective January 1, 2014, the government required almost everyone in the United States to have medical coverage. For those who don't have medical coverage, they will pay a penalty (the only exception is if you earn below a certain level of income). This requirement is called the individual mandate.

Meeting the Individual Mandate

In order to meet the individual mandate, you have several options:

Government-Sponsored Programs

If you meet a certain age, disability, income, or other qualification, you may be eligible for a U.S. government funded medical program, such as Medicare, Medicaid, CHIP, or TRICARE. Find out if you qualify for Medicare or Medicaid at www.cms.gov.

Health Insurance Marketplace or Individual Market

If you're not eligible to enroll in medical coverage through the City, the public health exchanges may be a good option for you. Visit www.coveredca.com or www.KeenanDirect.com for more information about health care reform and the exchanges that are available in California.

If you are eligible for medical coverage from the City, while you are welcome to apply for coverage through the marketplaces, you will be required to pay 100% of the cost.

Other Health Coverage

You can satisfy the individual mandate if you are eligible for other health benefits coverage that the department of Health and Human Services recognizes such as a state health benefits risk pool.

No Coverage

You also have the option to not have any health insurance in 2023. However, if you choose to be uninsured in 2023 you will pay a tax penalty when you file your 2023 taxes (to determine your potential tax penalty, go to www.HealthCare.gov).

Legal Notices

No Surprises Act Notice

Our medical plans are subject to the No Surprises Act, which limits the amount covered persons may have to pay for certain out-of-network surprise medical bills. More information about surprise billing requirements included under the No Surprises Act and similar state laws, can be found on the medical insurance company's website or the Plan Sponsor's website. Additional information may be found in your Explanation of Benefits for any affected claims.

Discrimination Is Against the Law

[Name of Plan Sponsor] complies with the applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics). City of Glendale does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for pregnancy hospital stay (for delivery) for a mother and her newborn generally may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply to this minimum length of stay. Early discharge is permitted only if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA) Annual Notice

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 818.548.2160.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, go to Anthem.com/ca (find a doctor) or kp.org (doctors and locations).

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

You do not need prior authorization from the plan or any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, go to Anthem.com/ca (find a doctor) or kp.org (doctors and locations).

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Anthem Blue Cross and Kaiser. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims, and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

Notice of Extended Coverage to Children Covered as Students

"Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who, as a condition of coverage, is enrolled in an institution of higher education. Please review the following information with respect to your dependent child's rights in the event student status is lost.

Michelle's Law requires the Plan to allow extended eligibility in some cases for a covered child who would lose eligibility for Plan coverage due to loss of full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- *Dependent child means a child who is a dependent of a plan participant and who is eligible under the terms of the Plan based on their student status and enrollment at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.*
- *Medically necessary leave of absence means a leave of absence or any other change in enrollment:*
  - Of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury;
  - Which is medically necessary; and,
  - Which causes the dependent child to lose student status under the terms of the Plan.

The dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- *One year after the first day of the leave of absence; or*
- *The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student).*

A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under covered medical, dental and vision plans (the "Plan"). **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than their gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or,
- You become divorced or legally separated from your spouse.

Legal Notices (continued)

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- The parent-employee dies;
- The parent-employee's employment ends for any reason other than their gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or,
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified of a Qualifying Event:

- The end of employment or reduction of hours of employment;
- Death of the employee; or,
- The employee becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if part of the employer's plan), are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted to the Plan Administrator.

Each notice must include all of the following items: the covered employee's full name, address, phone number and Social Security Number; the full name, address, phone number and Social Security Number of each affected dependent, as well as each dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the employer or Plan Administrator.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their dependent children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

Legal Notices (continued)

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. (See Notice and Election Procedures.)

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation of coverage, for a maximum of 36 months, if the Plan is properly notified about the second Qualifying Event. This extension may be available to the spouse and any dependent children receiving COBRA continuation of coverage if the employee or former employee dies; becomes entitled to Medicare (Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second Qualifying Event would have caused the spouse or the dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. (See Notice and Election Procedures.)

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

IF YOU HAVE QUESTIONS

For more information about the Marketplace, visit www.healthcare.gov.

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), has jurisdiction with respect to the COBRA continuation coverage requirements of the Public Health Service Act (PHSA) that apply to state and local government employers, including counties, municipalities, public school districts, and the group health plans that they sponsor (Public Sector COBRA). COBRA can be a daunting and complex area of federal law. If you have any questions or issues regarding Public Sector COBRA, you may contact the Plan Administrator or email HHS at phig@cms.hhs.gov.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for non-COBRA beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or the Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and/or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination for eligibility for such assistance.

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death, or Qualified Medical Child Support Order, you may be able to enroll yourself and/or your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption or placement for adoption or divorce (including legal separation and annulment).

For information about Special Enrollment Rights, please contact:

City of Glendale
Human Resources, Benefits Division
818.548.2160

Medicare Part D – Important Notice 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 City of Glendale 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.**
- **City of Glendale has determined that the prescription drug coverage offered by Anthem Blue Cross and Kaiser Medical Plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current City of Glendale coverage will not be affected. If you keep this coverage and elect Medicare, the City of Glendale coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current City of Glendale coverage, be aware that you and your dependents will be able to get this coverage back.

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 City of Glendale 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 (i.e., a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Legal Notices (continued)

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact the person listed below for further information. **Note:** You will 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 City of Glendale 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 will 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 your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800.MEDICARE (800-633-4227). TTY users should call 877-486-2048.

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

REMEMBER

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

Date:	February 13, 2023
Name of Entity / Sender:	City of Glendale
Contact:	Human Respources
Address:	613 E. Broadway, Room 100 Glendale, CA 91206
Phone:	818.548.2160

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

City of Glendale Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources, Benefits Division at 818.548.2160.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about City of Glendale in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through Covered California will begin November 1, 2022, and is anticipated to end on January 31, 2023. Open Enrollment for most other states will begin on November 1 and close on January 15 of each year. Some states have expanded the open enrollment period beyond January 15, 2023 for coverage to begin in 2023. Notably, Covered California continues its special enrollment periods for coverage beginning in 2023.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.12% (for 2023) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's medical plan. If you receive a premium savings for Marketplace coverage, the IRS may seek reimbursement of those funds.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered medical coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com. The information is numbered to correspond to the Marketplace application.

3. Employer name City of Glendale	**4. Employer Identification Number (EIN)** 95-6000714	
5. Employer address 613 E. Broadway, Room 100	**6. Employer phone number** 818.548.2110	
7. City Glendale	**8. State** CA	**9. ZIP code** 91206
10. Who can we contact about employee health coverage at this job? Benefits Division		
11. Phone number (if different from above) 818.548.2160	**12. Email address** benefits@glendaleca.gov	

As your employer, we offer coverage that meets the minimum value standard to the employees as described in this Guide. The coverage offered to you meets the minimum value standard and the cost of this coverage to you is intended to be affordable based on employee wages.

Legal Notices (continued)

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

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

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHIP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
800-221-3943 | TTY: Colorado relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service:
800-359-1991 | TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 855-692-6442

FLORIDA – Medicaid
Website:
http://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp/
Phone: 678-564-1162, press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 800-457-4584

Legal Notices (continued)

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 877-524-4718
Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 888-342-6207 (Medicaid hotline) or
855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 800-862-4840
TTY: 617-886-8102

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 800-657-3739

MISSOURI – Medicaid
Website:
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov/
Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
HIPP Program Toll-Free Phone: 800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888-365-3742

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 800-699-9075

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 888-549-0820

Legal Notices (continued)

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877-543-7669

VERMONT – Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp/
Medicaid Phone: 800-432-5924
CHIP Phone: 800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-Free Phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877-267-2323, Menu Option 4, Ext. 61565

Contact Information

The City of Glendale recognizes excellence and performance by providing comprehensive and competitive benefit programs for its employees. We are dedicated to offering you and your family a variety of benefits that help meet your needs in retirement.

For Questions About ...	Phone	E-mail / Website
Benefits or Enrolling		
• Employee Benefits	818.548.2160	benefits@glendaleca.gov
City's Retirement Process		
• Teri Taylan, Benefits Manager	818.548.2110	ttaylan@glendaleca.gov
City's Retirement Billing		
• PayFlex	800.359.3921	www.payflex.com
City's Deferred Compensation Plans and RHSP		
• Appointments for MissionSquare Retirement *(formerly ICMA)*	https://icmarc.secure.force.com/events?SiteId=a0lj0000003QO3LAAW	
• Mission Square Retirement *(formerly ICMA) Account Information)*	800.669.7400	www.missionsq.org/
Medical Plans		
• Anthem Blue Cross		
– PPO, HMO & HDHP/HSA	800.288.2539	www.anthem.com/ca
– Senior Secure	800.225.2273	
• Anthem Rx *(Mail Order name changed to CarelonRx)*	866.274.6825	www.anthem.com/ca
• Kaiser Permanente	800.464.4000	www.kp.org
• FuturisCare Retiree Services	888.616.7130	www.healthcompare.com/futuriscare
• Keenan Direct	855.359.7354	www.keenandirect.com
Dental Plans		
• Guardian		
• PPO	800.541.7846	www.guardiananytime.com
• MDC Managed Dental Care (DMO)	800.459.9401	www.guardiananytime.com
Vision Plan		
• Vision Service Plan (VSP)	800.877.7195	www.vsp.com
Pension Plans		
• CalPERS 655 N. Central Avenue, Suite 1400 Glendale, CA 91203	888.225.7377	www.calpers.ca.gov
• PARS-ARS	800.540.6369	www.pars.org
Social Security and Medicare		
• Social Security Administration	800.772.1213	www.ssa.gov

Glossary

Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, reduced FSA contributions, covering preventive care without cost-sharing, etc, among other requirements.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Brand Name Drug

The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

The Consolidated Omnibus Budget Reconciliation Act allows people who lose their jobs to continue their employer-sponsored insurance coverage for up to 18 months.

Children's Health Insurance Program (CHIP)

The government program that provides free or low-cost health coverage for children up to age 19 in families whose income is too high to qualify for Medicaid but too low to afford private insurance. CHIP covers U.S. citizens and eligible immigrants. In some states, CHIP covers pregnant people. CHIP goes by different names in some states.

Claim

A request for payment that you or your health care provider submits to your health insurer to be paid or reimbursed for items or services you have received. Most often, you will not be responsible for making claim requests. Usually, billing and claims specialists employed by the health care provider (e.g. primary care office, hospital) will make the claim on your behalf.

Coinsurance

A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)

A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Comprehensive Coverage

A health insurance plan that covers the full range of care that you may need. This may include preventive services (like flu shots), physical exams, prescription drugs, and doctor or hospital care.

Deductible

The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Formulary

A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Generic Drug

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)

High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

Glossary (continued)

Health Savings Account (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax- free basis. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Health Reimbursement Arrangements (HRAs)

Unlike HSAs, only an employer may fund an HRA and the funds revert back to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs, and they may be paired with either high-deductible plans or traditional health plans.

In-Network

Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Out-of-Pocket Maximum

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Out-Of-Network

A health plan will cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-Of-Pocket Limit

The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including co-payments and co-insurance.

Plan Year

The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Premium

The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

Preventive Care

Health care services you receive when you are not sick or injured— so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

Qualifying Life Event

A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include moving to a new state, certain changes in your income, and changes in your family size.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Click here to watch a video on Benefits Key Terms Explained.