Ready, Set, Enroll!

City of Glendale
2024-2025 Active Benefits

2024-25 Monthly Rates: Active

Effective 06/01/2024 - 05/31/2025

ACA Eligible

Medical	Anthem Prudent Buyer PPO			Anthem CaliforniaCare HMO		
	Employee's Contribution	City's Contribution	Total Monthly	Employee's Contribution	City's Contribution	Total Monthly
Single	$440.82	$363.00	$803.82	$620.72	$363.00	$983.72
Two-Party	$1,693.97	$363.00	$2,056.97	$1,702.78	$363.00	$2,065.78
Family	$2,554.16	$363.00	$2,917.16	$2,587.93	$363.00	$2,950.93

ACA Eligible

Medical	KAISER PERMANENTE					
	Traditional High Option HMO			Deductible Low Option HMO		
	Employee's Contribution	City's Contribution	Total Monthly	Employee's Contribution	City's Contribution	Total Monthly
Single	$282.80	$363.00	$645.80	$174.51	$363.00	$537.51
Two-Party	$928.61	$363.00	$1,291.61	$712.03	$363.00	$1,075.03
Family	$1,464.63	$363.00	$1,827.63	$1,158.16	$363.00	$1,521.16

ACA Eligible

Medical	Anthem High Deductible Health Plan		
	Employee's Contribution	City's Contribution	Total Monthly
Single	$164.35	$363.00	$527.35
Two-Party	$744.43	$363.00	$1,107.43
Family	$1,219.05	$363.00	$1,582.05

Glendale City Employees Association (GCEA)

Medical	Anthem Prudent Buyer PPO			Anthem CaliforniaCare HMO		
	Employee's Contribution	City's Contribution	Total Monthly	Employee's Contribution	City's Contribution	Total Monthly
Single	$111.56	$692.26	$803.82	$191.04	$792.68	$983.72
Two-Party	$285.74	$1,771.23	$2,056.97	$458.79	$1,606.99	$2,065.78
Family	$529.53	$2,387.63	$2,917.16	$782.24	$2,168.69	$2,950.93

Glendale City Employees Association (GCEA)

Medical	KAISER PERMANENTE					
	Traditional High Option HMO			Deductible Low Option HMO		
	Employee's Contribution	City's Contribution	Total Monthly	Employee's Contribution	City's Contribution	Total Monthly
Single	$60.28	$585.52	$645.80	$50.13	$487.38	$537.51
Two-Party	$120.57	$1,171.04	$1,291.61	$100.29	$974.74	$1,075.03
Family	$170.63	$1,657.00	$1,827.63	$141.92	$1,379.24	$1,521.16

Glendale City Employees Association (GCEA)

Medical	Anthem High Deductible Health Plan		
	Employee's Contribution	City's Contribution	Total Monthly
Single	$69.70	$457.65	$527.35
Two-Party	$146.49	$960.94	$1,107.43
Family	$277.91	$1,304.14	$1,582.05

2024-25 Monthly Rates: Active

Effective 06/01/2024 - 05/31/2025

International Brotherhood of Electrical Workers (IBEW)

Medical	Anthem Prudent Buyer PPO			Anthem CaliforniaCare HMO		
	Employee's Contribution	City's Contribution	Total Monthly	Employee's Contribution	City's Contribution	Total Monthly
Single	$277.62	$526.20	$803.82	$415.54	$568.18	$983.72
Two-Party	$723.35	$1,333.62	$2,056.97	$884.63	$1,181.15	$2,065.78
Family	$1,026.86	$1,890.30	$2,917.16	$1,257.44	$1,693.49	$2,950.93

International Brotherhood of Electrical Workers (IBEW)

Medical	KAISER PERMANENTE					
	Traditional High Option HMO			Deductible Low Option HMO		
	Employee's Contribution	City's Contribution	Total Monthly	Employee's Contribution	City's Contribution	Total Monthly
Single	$254.36	$391.44	$645.80	$200.20	$337.31	$537.51
Two-Party	$508.91	$782.70	$1,291.61	$400.61	$674.42	$1,075.03
Family	$719.89	$1,107.74	$1,827.63	$566.68	$954.48	$1,521.16

International Brotherhood of Electrical Workers (IBEW)

Medical	Anthem High Deductible Health Plan		
	Employee's Contribution	City's Contribution	Total Monthly
Single	$180.65	$346.70	$527.35
Two-Party	$386.42	$721.01	$1,107.43
Family	$552.58	$1,029.47	$1,582.05

Glendale Fire Fighters Association (GFFA)

Medical	Anthem Prudent Buyer PPO			Anthem CaliforniaCare HMO		
	Employee's Contribution	City's Contribution	Total Monthly	Employee's Contribution	City's Contribution	Total Monthly
Single	$111.56	$692.26	$803.82	$191.04	$792.68	$983.72
Two-Party	$285.74	$1,771.23	$2,056.97	$458.79	$1,606.99	$2,065.78
Family	$529.53	$2,387.63	$2,917.16	$782.24	$2,168.69	$2,950.93

Glendale Fire Fighters Association (GFFA)

Medical	KAISER PERMANENTE					
	Traditional High Option HMO			Deductible Low Option HMO		
	Employee's Contribution	City's Contribution	Total Monthly	Employee's Contribution	City's Contribution	Total Monthly
Single	$60.28	$585.52	$645.80	$50.13	$487.38	$537.51
Two-Party	$120.57	$1,171.04	$1,291.61	$100.29	$974.74	$1,075.03
Family	$170.63	$1,657.00	$1,827.63	$141.92	$1,379.24	$1,521.16

Glendale Fire Fighters Association (GFFA)

Medical	Anthem High Deductible Health Plan		
	Employee's Contribution	City's Contribution	Total Monthly
Single	$69.70	$457.65	$527.35
Two-Party	$146.49	$960.94	$1,107.43
Family	$277.91	$1,304.14	$1,582.05

2024-25 Monthly Rates: Active

Effective 06/01/2024 - 05/31/2025

Glendale Police Officers Association (GPOA)

Medical	Anthem Prudent Buyer PPO			Anthem CaliforniaCare HMO		
	Employee's Contribution	City's Contribution	Total Monthly	Employee's Contribution	City's Contribution	Total Monthly
Single	$111.56	$692.26	$803.82	$191.04	$792.68	$983.72
Two-Party	$285.74	$1,771.23	$2,056.97	$458.79	$1,606.99	$2,065.78
Family	$529.53	$2,387.63	$2,917.16	$782.24	$2,168.69	$2,950.93

Glendale Police Officers Association (GPOA)

Medical	KAISER PERMANENTE					
	Traditional High Option HMO			Deductible Low Option HMO		
	Employee's Contribution	City's Contribution	Total Monthly	Employee's Contribution	City's Contribution	Total Monthly
Single	$60.28	$585.52	$645.80	$50.13	$487.38	$537.51
Two-Party	$120.57	$1,171.04	$1,291.61	$100.29	$974.74	$1,075.03
Family	$170.63	$1,657.00	$1,827.63	$141.92	$1,379.24	$1,521.16

Glendale Police Officers Association (GPOA)

Medical	Anthem High Deductible Health Plan		
	Employee's Contribution	City's Contribution	Total Monthly
Single	$69.70	$457.65	$527.35
Two-Party	$146.49	$960.94	$1,107.43
Family	$277.91	$1,304.14	$1,582.05

Executives and Glendale Management Association (GMA)

Medical	Anthem Prudent Buyer PPO			Anthem CaliforniaCare HMO		
	Employee's Contribution	City's Contribution	Total Monthly	Employee's Contribution	City's Contribution	Total Monthly
Single	$111.56	$692.26	$803.82	$191.04	$792.68	$983.72
Two-Party	$285.74	$1,771.23	$2,056.97	$458.79	$1,606.99	$2,065.78
Family	$529.53	$2,387.63	$2,917.16	$782.24	$2,168.69	$2,950.93

Executives and Glendale Management Association (GMA)

Medical	KAISER PERMANENTE					
	Traditional High Option HMO			Deductible Low Option HMO		
	Employee's Contribution	City's Contribution	Total Monthly	Employee's Contribution	City's Contribution	Total Monthly
Single	$60.28	$585.52	$645.80	$50.13	$487.38	$537.51
Two-Party	$120.57	$1,171.04	$1,291.61	$100.29	$974.74	$1,075.03
Family	$170.63	$1,657.00	$1,827.63	$141.92	$1,379.24	$1,521.16

Executives and Glendale Management Association (GMA)

Medical	Anthem High Deductible Health Plan		
	Employee's Contribution	City's Contribution	Total Monthly
Single	$69.70	$457.65	$527.35
Two-Party	$146.49	$960.94	$1,107.43
Family	$277.91	$1,304.14	$1,582.05

2024-25 Monthly Rates: Active

Effective 06/01/2024 - 05/31/2025

Glendale Management Association - Police (GMAP)

Medical	Anthem Prudent Buyer PPO			Anthem CaliforniaCare HMO		
	Employee's Contribution	City's Contribution	Total Monthly	Employee's Contribution	City's Contribution	Total Monthly
Single	$111.56	$692.26	$803.82	$191.04	$792.68	$983.72
Two-Party	$285.74	$1,771.23	$2,056.97	$458.79	$1,606.99	$2,065.78
Family	$529.53	$2,387.63	$2,917.16	$782.24	$2,168.69	$2,950.93

Glendale Management Association - Police (GMAP)

Medical	KAISER PERMANENTE					
	Traditional High Option HMO			Deductible Low Option HMO		
	Employee's Contribution	City's Contribution	Total Monthly	Employee's Contribution	City's Contribution	Total Monthly
Single	$60.28	$585.52	$645.80	$50.13	$487.38	$537.51
Two-Party	$120.57	$1,171.04	$1,291.61	$100.29	$974.74	$1,075.03
Family	$170.63	$1,657.00	$1,827.63	$141.92	$1,379.24	$1,521.16

Glendale Management Association - Police (GMAP)

Medical	Anthem High Deductible Health Plan		
	Employee's Contribution	City's Contribution	Total Monthly
Single	$69.70	$457.65	$527.35
Two-Party	$146.49	$960.94	$1,107.43
Family	$277.91	$1,304.14	$1,582.05

	GUARDIAN DENTAL PLAN					
	High Option PPO (*only with Anthem PPO)			Buy-Up PPO		
	Employee's Contribution	City's Contribution	Total Monthly	Employee's Contribution	City's Contribution	Total Monthly
Single	$0.00	$44.84	$44.84	$18.46	$18.36	$36.82
Two-Party	$0.00	$76.22	$76.22	$28.93	$33.63	$62.56
Family	$0.00	$116.57	$116.57	$44.38	$51.33	$95.71

	GUARDIAN DENTAL PLAN MDC-G90 DMO			Vision Service Plan - VSP		
	Employee's Contribution	City's Contribution	Total Monthly	Employee's Contribution	City's Contribution	Total Monthly
Single	$0.00	$18.36	$18.36	$0.00	$8.75	$8.75
Two-Party	$0.00	$33.63	$33.63	$0.00	$14.97	$14.97
Family	$0.00	$51.33	$51.33	$0.00	$23.71	$23.71

CONTENTS

MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

GETTING STARTED

2024-2025 Benefits

June 1, 2024, through May 31, 2025

IMPORTANT NOTE:
This guide is a summary overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan documents including your benefit summaries, summary of benefits and coverage (SBCs) and summary plan descriptions (SPDs). The plan documents determine how all benefits are paid.

No matter where you are in your career, The City of Glendale supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, as well as life, disability, retirement, and more benefits.

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

WHO'S ELIGIBLE FOR BENEFITS?

Employees

You are eligible if you are an active Full-time Salaried employee.

You are an eligible hourly employee (as defined by rules outlined under the Affordable Care Act).

Eligible dependents

- Legally married spouse.
- Your domestic partner, if you are legally registered with the State of California and have a complete and notarized Declaration of Domestic Partnership Affidavit.
- Biological, adopted, or stepchildren up to age 26.
- Children over age 26 who are disabled and depend on you for support
- Children named in a qualified medical child support order (QMCSO)

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

Dependent Verification

- Spouse – a copy of marriage certificate and your spouse's social security card.
- Domestic Partner – a copy of the registered, filed State of California Domestic Partnership Registration, a notarized Declaration of Domestic Partnership Affidavit, and your domestic partner's Social Security Card.
- Child(ren) – a copy of the birth certificate (or certificate from the hospital for newborns only) and Social Security Card.

When you can enroll

New and newly eligible employees must enroll within 30 days of their start date, with coverage effective the first of the following month after eligibility occurred.

Existing employees can make changes during the annual open enrollment period, or sooner if they have a qualifying event.

If you miss the enrollment deadline, you will need to wait until the next open enrollment.

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

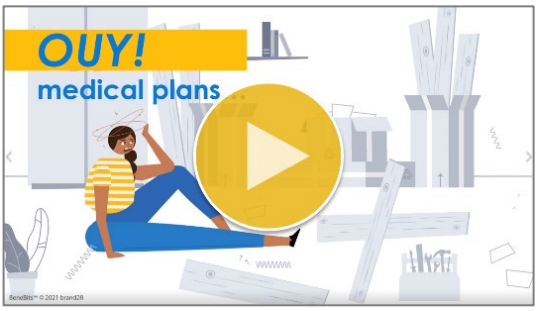
A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

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

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

You must submit any changes within 30 days after the event.

WHICH PLAN IS RIGHT FOR YOU?



All About Medical Plans

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

Consider an HMO (health maintenance organization) if:

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

Plans To Consider

- Anthem HMO Plan
- Kaiser Traditional HMO Plan
- Kaiser Deductible HMO Plan

Consider a PPO (preferred provider organization) if:

- You want to be able to see any provider, even a specialist, without a referral.
- You want coverage for out-of-network providers (at a higher cost).

Plans To Consider

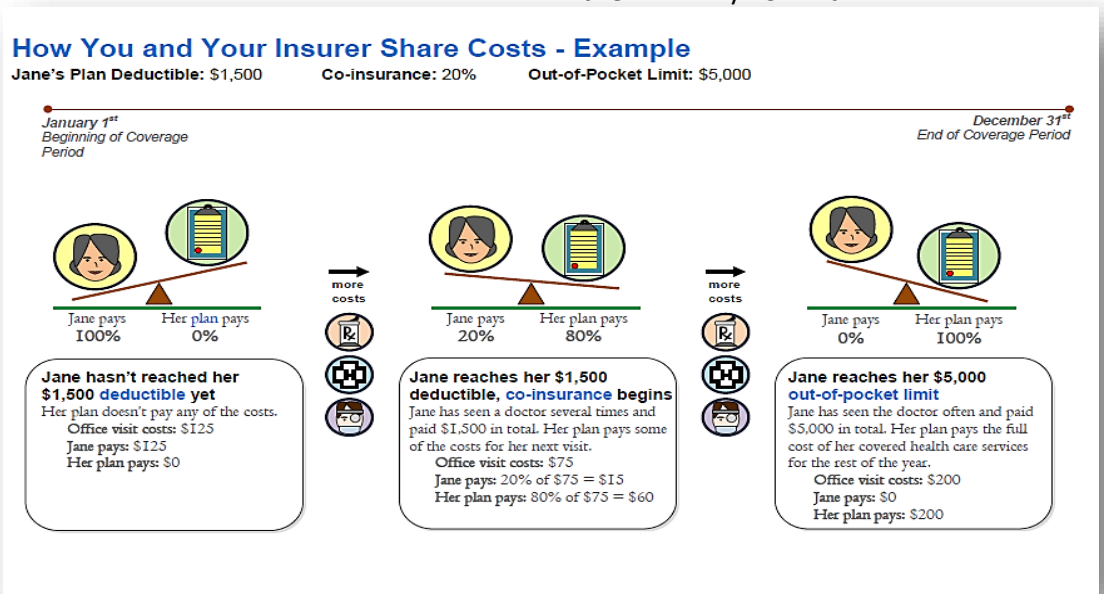
- Anthem PPO Plan

Consider a high deductible health plan (HDHP) if:

- You want to be able to see any provider, even a specialist, without a referral.
- You want coverage for out-of-network providers (at a higher cost).
- You want tax-free savings on your healthcare costs.
- You want to build a savings account for future healthcare costs for you and your eligible family members.
- You want an extra way to add to your retirement savings.

Plans To Consider

- Anthem HDHP/HSA Plan



DO YOU HAVE QUESTIONS ABOUT YOUR BENEFITS?

Click to play video

CONTACT YOUR ALLIANT BENEFIT ADVOCATE

Email:
benefitsupport@alliant.com

Phone

(800) 489-1390

Hours

5 a.m.–5 p.m. (Pacific Time)
Monday–Friday

Get help from a Benefit Advocate

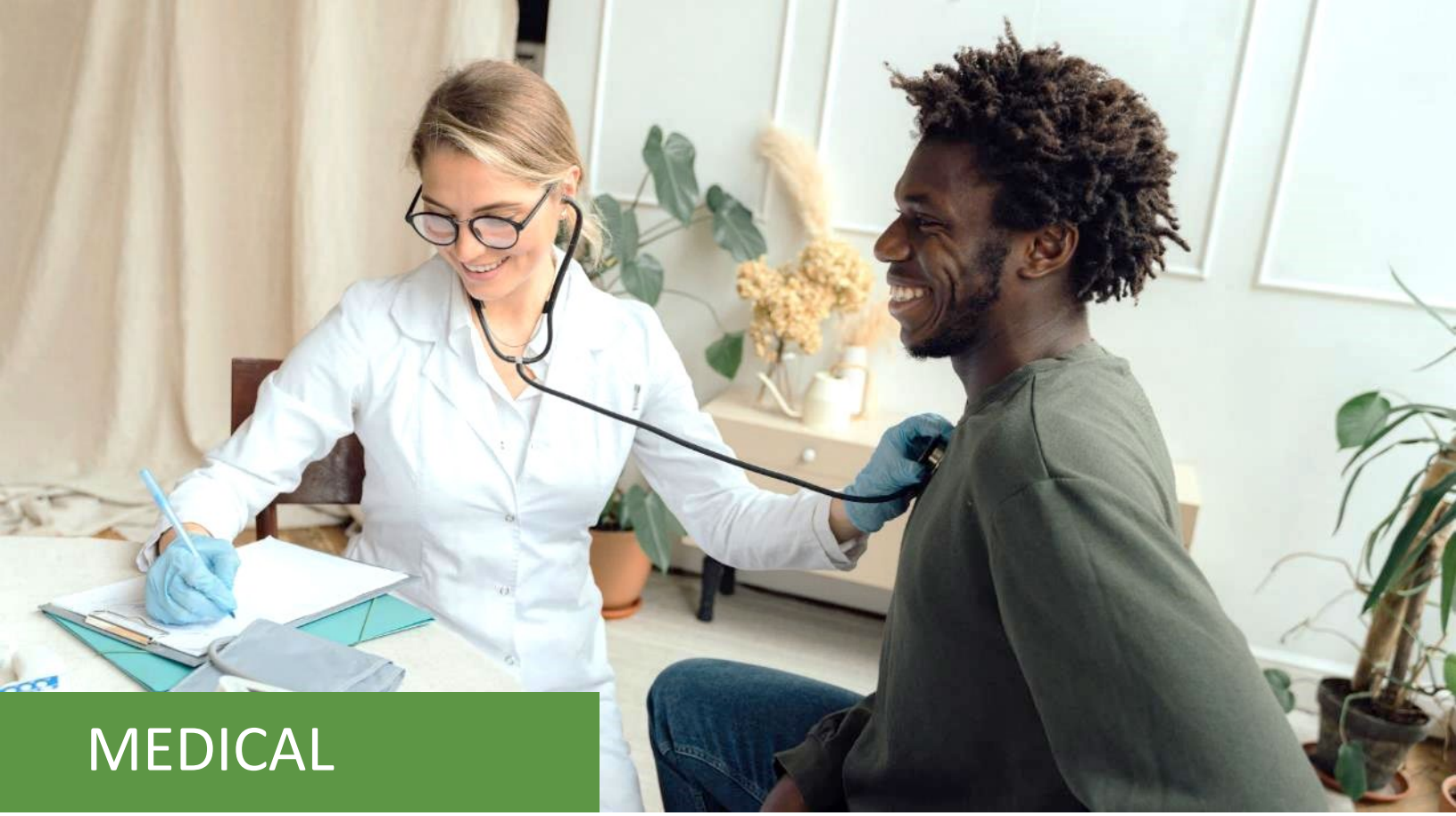
Are you getting married and you're not sure how or when to add your new spouse to your plan? Is your stepchild eligible for your healthcare plan? Do you need help understanding the difference between an HSA and an FSA? A Benefit Advocate can help answer these questions and more.

Benefit Advocates are trained benefit experts who can help you understand and use your healthcare benefits and other coverage. Contact your Benefit Advocate for issues such as:

- General benefit questions
- Eligibility and coverage
- Finding a network provider
- Problems with health care claims or billing, when warranted
- Coverage changes due to life events (such as marriage, a new child, or divorce)

Claims assistance

If you need claims assistance, you may need to complete a HIPAA authorization form to grant your Benefit Advocate permission to work with your insurer and/or healthcare provider(s) to resolve your claims issues. Permission is granted on a limited-duration basis, and only to the individuals listed on the form. You can end the permissions granted by the form at any time. Your Benefit Advocate will provide the form to you when needed.



MEDICAL

OUR PLANS

Anthem PPO 80/60

Anthem PPO HDHP/HSA

Anthem HMO

Kaiser Traditional HMO

Kaiser Deductible HMO

Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Think about these factors when choosing your medical plan:

Do you like your doctors?

Check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more, consider a plan with out-of-network coverage.

What are your healthcare needs?

Compare how each plan covers the services you need most often, such as office visits, specialists, or prescriptions.

What's your budget?

What will you pay for coverage? Is there a deductible? What is your share of the cost for office visits and prescriptions? All of these factors together affect your total cost for healthcare.

ANTHEM PPO PLANS

The Plans At-a-Glance are intended to provide a general overview. For specific information, see Summary of Benefits & Coverages (SBCs).

	PPO – Prudent Buyer		PPO HDHP/HSA Prudent Buyer	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Deductible	Individual: $200 Family: $400	Individual: $400 Family: $800	Individual: $1.600 Member: $3,200 Family: $4,000 **Subject to change every year on January 1	Individual: $4.500 Member: $4,500 Family: $9,000 **Subject to change every year on January 1
Annual Out-of-Pocket Maximum	Individual: $2,000 Family: $4,000	Individual: $4,000 Family: $8,000 *Could be unlimited due to balance billing with Out-of-Network providers.	Individual: $4,000 Member:$4,000 Family: $8,000 **Subject to change every year on January 1	Individual: $9,000 Member: $9,000 Family: $18,000 *Could be unlimited due to balance billing with Out-of-Network providers. **Subject to change every year on January 1
Office Visit	$10 copay $10 copay for specialist	40%* 40%for specialist*	20% 20% for specialist	40%*
Online Visit	$10 copay	40%*	20%	40%*
Chiropractic	20%	40%*	20%	40%*
Lab and X-ray	20%	40%*	20%	40%*
Urgent Care	$10 copay	40%*	20%	40%*
Emergency Room	$100 copay/visit + 20% ($100 waived if admitted)	Covered as In-Network	20%	Covered as In-Network
Hospitalization	20%	40%*	20%	40%*
Outpatient Surgery	No charge	40%*	20%	40%*
PRESCRIPTION DRUGS				
Deductible	None	None	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Out-of-Pocket Maximum	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Combined with Non-Network medical out-of-pocket limit
Generic	$10 copay (retail and home delivery)	50% up to $250 per prescription (retail). Not covered (home delivery)	**Lowest cost generic** $5 copay. (retail) and $10 copay (home delivery). **Generic** $15 copay (retail) and $30 (home delivery)	40% up to $250 per prescription (retail). Not covered (home delivery)
Brand Name	**Preferred**: $20 (retail and home delivery) **Non-Preferred:** $20 (retail and home delivery)	50% up to $250 per prescription (retail). Not covered (home delivery)	**Preferred**: $40 copay (retail) and $100 copay (home delivery) **Non-Preferred**:$60 copay (retail) and $150 copay (home delivery)	40% up to $250 per prescription (retail). Not covered (home delivery)
Specialty	$20 copay (retail and home delivery)	Not covered (retail and home delivery)	30% up to $250 (retail and home delivery)	40% up to $250 per prescription (retail). Not covered (home delivery)
Supply Limits	Retail – 30 day Home delivery - 90 day	Retail – 30 day Home delivery - 90 day	Retail – 30 day Home delivery - 90 day	Retail – 30 day Home delivery - 90 day

ANTHEM AND KAISER HMO PLANS

	Anthem HMO Plan	Kaiser Traditional HMO Plan	Kaiser Deductible HMO Plan
	In-Network	In-Network	In-Network
Annual Deductible	Individual: $0 Family: $0	Individual: $0 Family: $0	Individual: $1.000 Family: $2,000
Annual Out-of-Pocket Maximum	Individual: $500 Family: $1,500	Individual: $1,500 Family: $3,000	Individual: $3,000 Family: $6,000
Office Visit	$10 copay $10 copay for specialist	$10 copay $10 copay for specialist	$20 copay $20 copay for specialist
Online Visit	$10 copay	No charge	No charge
Chiropractic	No charge	$10 copay (30 visits)	$10 copay (30 visits)
Lab and X-ray	No charge	No charge	$10 copay
Urgent Care	$10 copay	$10 copay	$20 copay
Emergency Room	$25 copay (copay waived if admitted)	$50 copay (copy waived if admitted)	20% after plan deductible
Hospitalization	No charge	No charge	20% after plan deductible
Outpatient Surgery	No charge	$10 copay	20% after plan deductible
PRESCRIPTION DRUGS			
Deductible	None	None	None
Out-of-Pocket Maximum	Combined with In-Network medical out-of-pocket limit	None	None
Generic	$5 copay (retail 30-day supply) and home delivery 90-day supply)	$5 copay (retail and home delivery 100-day supply)	$10 copay (retail 30-day supply) $20 copay (home delivery 100-day supply)
Brand Name	**Preferred:** $10 copay (retail 30-day supply and home delivery 90-day supply) **Non-Preferred**:$10 copay (retail 30-day supply and home delivery 90-day supply)	$10 copay (retail and home delivery 100-day supply)	$30 copay (retail 30-day supply) $60 copay (home delivery 100-day supply)
Specialty brand and generic	$10 copay (retail 30-day supply and home delivery 90-day supply)	$10 copay (retail 30-day supply)	$30 copay (retail 30-day supply)

The Plans At-a-Glance are intended to provide a general overview. For specific information, see Summary of Benefits & Coverages (SBCs).

HEALTH SAVINGS ACCOUNT (HSA)

Click to play video

ARE YOU ELIGIBLE?

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

1. Enrolled in the Anthem HDHP Plan
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.
4. Not enrolled in a healthcare Flexible Spending Account (FSA)

A personal savings account for healthcare

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

How the Anthem HSA works

- Your HSA account is set up automatically after you enroll.
- You can contribute up to the limit set by the IRS.

  Individual: $4,150 per year *2024 calendar year limit
  Family: $8,300 per year *2024 calendar year limit
  Are you age 55? You can contribute an additional $1,000 per year.
- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save the money to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free. You can also use it for regular living expenses, which will be taxable but without penalties.

Find out more

- The Easy Guide to Understanding Your HDHP/HSA click on the link. HDHP/HSA
- Eligible Expenses
- Ineligible Expenses

See a doctor or therapist when it works for you

Using LiveHealth Online, any time works for a video visit with a doctor or therapist.

If you need care for a health issue, or support if you're feeling anxious or having trouble coping on your own, LiveHealth Online is ready to help. You can stay home and have a video visit with a board-certified doctor or licensed therapist on your smartphone, tablet or computer.

By using LiveHealth Online, you can

- **See a board-certified doctor in a few minutes with no appointment.** Doctors are available 24/7 to assess your condition and, if it's needed, they can send a prescription to your local pharmacy.[1] When your own doctor isn't available, use LiveHealth Online if you have pinkeye, a cold, the flu, a fever, allergies, a sinus infection or another common health condition.
- **Make an appointment with a licensed therapist in four days or less.**[2] You can have a video visit with a therapist from home, at work or on the go — evenings and weekend appointments are available too. Appointments can be scheduled online or over the phone at **1-888-548-3432** from 7 a.m. to 7 p.m., seven days a week. You can get help for anxiety, depression, grief, panic attacks and more.

What will a visit cost?

Your Anthem plan includes benefits for video visits using LiveHealth Online, so you'll just pay your share of the costs — usually $59 or less for medical doctor visits, and a 45-minute therapy session usually costs the same as an office therapy visit.

Sign up for LiveHealth Online today – it's quick and easy

Go to **livehealthonline.com** or download the app and register on your phone or tablet.

Download on the App Store | ANDROID APP ON Google play

Anthem | LiveHealth ONLINE

LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem Blue Cross.

Anthem.

Anthem's Sydney Health app makes healthcare easier

Look up your personalized health and wellness information from anywhere

If you have an Anthem health plan, our Sydney℠ Health app can help you make the most of your benefits. Download and use the app to:

- View and use your **digital ID card**.
- Have a **video visit** with a doctor or mental health professional.[1,2]
- **See what's covered** and **check your claims**.
- **Locate care** nearby and **check the cost**.
- Look up your **health history and medical records** — and your family's — with My Health Records.
- Chat with **a live agent** to get answers to your healthcare questions.
- Discover **well-being tips** on your MyHealth Dashboard.
- Find organizations that can help you with **food, transportation, and child care**.

Customized tools to help you stay in good health

The Personalized Preventative Care Checklist uses your claims history to notify you when it's time for you to take preventive care action and helps you plan for future actions.

The Nutrition Tracker logs your meals and tracks your nutrition using food-scanning technology. It also helps you meal plan.

Download our Sydney Health app today!

sydney™

Scan the QR code with your phone's camera or visit anthem.com/ca to use the same features on our website.

With you every step of the way

Emotional Well-being Resources offer help when you need it

Your emotional health is an important part of your overall health. With Emotional Well-being Resources, administered by Learn to Live, you can receive support to help you live your happiest, healthiest life.

Built on the proven principles of Cognitive Behavioral Therapy (CBT), our digital tools are available anywhere, anytime. They can help you identify thoughts and behavior patterns that affect your emotional well-being – and work through them. You'll learn effective ways to manage stress, depression, anxiety, substance use, and sleep issues.

Change your mind. Change your life.™

Take a quick assessment to find the program that's right for you. To access our Emotional Well-being Resources:

Log in to **anthem.com/ca**, go to **My Health Dashboard**, choose **Programs**, and select **Emotional Well-being Resources.**

Effective: 1/1/22

A wealth of resources at your fingertips

Personalized, one-on-one coaching

Team up with an experienced coach who can provide support and encouragement by email, text, or phone.

Build a support team

Add friends or family members as "Teammates." They can help you stay motivated and accountable while you work through programs.

Practice mindfulness on the go

Receive weekly text messages filled with positivity, quick tips, and exercises to improve your mood.

Live and on-demand webinars

Learn how to improve mental well-being with useful tips and advice from experts.

Anthem

learntolive

KAISER RESOURCES

Convenient ways to get what you need

You've got more ways to get quality care than ever before, so it's easier to stay on top of your health.

Video or phone appointment

Schedule a face-to-face video visit or phone appointment with a Kaiser Permanente care team and any specialists you've been referred to.

In-person care

We offer same-day, next-day, after-hours, and weekend services at many of our locations.

Email

Message your Kaiser Permanente doctor's office with nonurgent questions and get a reply usually within 2 business days.

Prescription delivery

Use the Kaiser Permanente app to fill prescriptions for delivery or same-day pickup.

24/7 advice

Get on-demand support with 24/7 care advice by phone.

E-visit

Use our online symptom checker for certain conditions and get personalized care advice within a few hours.

Care away from home

You're covered for emergency care anywhere in the world. When you're not in a Kaiser Permanente area, get urgent care from any provider, including MinuteClinic locations (in select CVS and Target stores) or Concentra urgent care centers.

To learn more, visit Kaiser Permanente

KAISER RESOURCES

Making the most of your membership

Good health goes beyond the doctor's office. Find your healthy place by exploring some of the convenient features and extras available to members. Many of these resources are available at no additional cost.

Kaiser Permanente app

Manage your health 24/7 — schedule appointments, email your doctor's office with nonurgent questions, order most prescription refills, see most test results, read your doctor's notes, and more.

Acupuncture, massage therapy, chiropractic care

Enjoy reduced rates on services to help you stay healthy.

Reduced rates on gym memberships

Stay active by joining a local fitness center, plus enjoy thousands of digital workout videos.

Healthy lifestyle programs

Connect to better health with online programs to help you lose weight, quit smoking, reduce stress, and more.

Wellness coaching

Get help reaching your health goals by working one-on-one with a wellness coach by phone.

Extras for your total health

Calm

Adult members can use meditation and mindfulness to build mental resilience, reduce stress, and improve sleep.

myStrength

Adult members can set mental health goals, track progress, and get support managing depression, anxiety, and more.

Choose from thousands of on-demand workout videos and get reduced rates on livestream and in-person classes.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

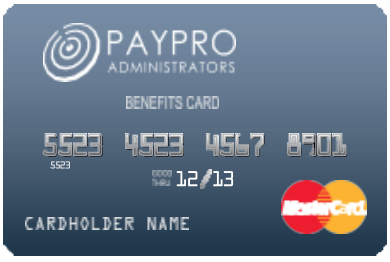
Click to play video

ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in a high deductible health plan, like our Anthem **HDHP** PLAN, **you cannot participate in the Healthcare FSA**.

Find out more

- www.pagroup.us
- Eligible Expenses – now include more over-the-counter items!
- Ineligible Expenses



Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year.

How the FSA PayPro works

- You estimate what you and your dependents' out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, and even eligible drugstore items.
- You can contribute up to $3,200, the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Estimate carefully!

If you don't spend all the money in your account, you can roll over up to $640 to use the following year. Any additional remaining balance will be forfeited.

Dependent Care FSA Account

This plan allows you to pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. Eligible expenses may include daycare centers, in- home childcare, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are considered your tax dependent and are incapable of self- care. It is important to note that you can access money only after it is placed into your dependent care FSA account. You can set aside up to $5,000 per household for eligible dependents care expenses for the year.

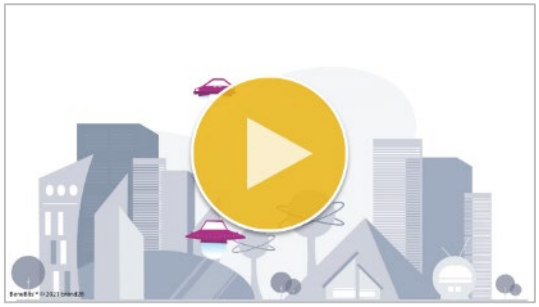
Check your balance and claims online at www.pagroup.us or call (800) 427-4549 or fax to (951) 346-4244

KNOW WHERE TO GO

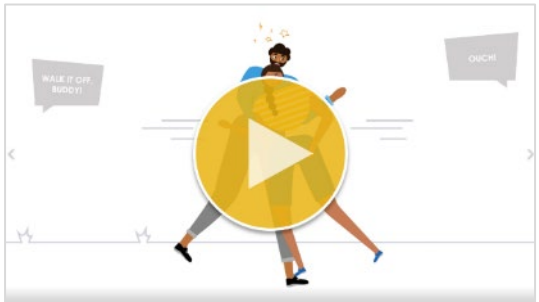
Where you get medical care can significantly influence the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Examples
Nurse line (24/7—$0) Quick answers from a trained nurse	Identifying if immediate care is needed Home treatment options and advice
Online visit (24/7—$) Many nonemergency health issues	Cold, flu, allergies, headache, migraine Skin conditions, rashes Minor injuries Mental health concerns
Office visit ($$) Routine medical care and management	Preventive care Illnesses, injuries Managing existing conditions
Urgent care ($$$) Non-life-threatening conditions requiring prompt attention	Stitches, sprains Animal bites High fever, respiratory infections
Emergency room (24/7—$$$$) Life-threatening conditions needing immediate care	Suspected heart attack or stroke Major bone breaks Excessive bleeding Severe pain Difficulty breathing

Click to play videos



Virtual Healthcare



Urgent Care vs ER

PREVENTIVE CARE

TYPICAL SCREENINGS FOR ADULTS

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

You take your car in for maintenance; why not do the same for yourself?

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

Health plans are required to cover a set of preventive services at no cost to you, even if you haven't met your deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Be aware: Not all exams and tests are considered preventive care

Certain screenings may be considered diagnostic, rather than preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

In addition, exams performed by specialists are generally not considered preventive care and may not be covered at 100%.

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

Preventive care for women should include breast and gynecological exams.

For men, preventive care should include prostate cancer screening and a testicular exam.

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Understanding the formulary can save you money

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

What is a formulary?

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

Get the most from your coverage

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

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

DENTAL

OUR PLANS

Guardian High Option PPO and Buy-Up PPO

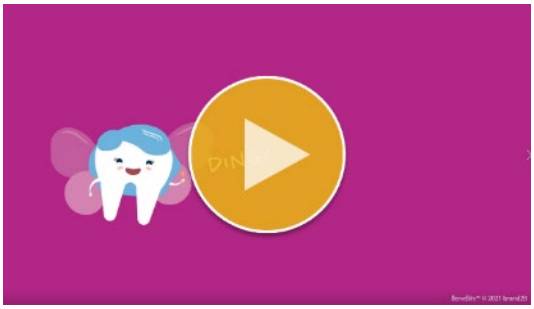
Guardian MDC-G90 DMO

Why sign up for dental coverage?

Brushing and flossing are great, but regular exams catch dental issues early. If there's a problem, our dental plan makes it easier and less expensive to get the care you need to maintain your smile.

Find out how it works!

Click to play video



DENTAL

Does not include Hourly ACA-eligible.

	Guardian MDC-G90 DMO Managed Dental Care Option 1	Guardian Buy-Up PPO Option 2		Guardian High Option PPO (Only available if enrolled in Anthem Blue Cross Prudent Buyer PPO Medical Plan or waived medical coverage. Option 3	
	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	None	$50 (waived for preventive)	$50	$50 (waived for preventive)	$50 (waived for preventive)
Annual Plan Maximum	N/A	$1000	$1000	$1,500	$1000
Diagnostic & Preventive	$0	80%	80%	100%	100%
Basic Services	$0 - $95	80%	60%	90%	80%
○ Fillings	$0	80%	60%	90%	80%
○ Extractions	$0 -$40	80%	60%	90%	80%
○ Root Canal	$0 - $90	80%	60%	90%	80%
Major Services	$90 - $130	50%	40%	60%	50%
○ Bridges and Dentures	$110 - $130	50%	40%	60%	50%
○ Crowns	$90	50%	40%	60%	50%
Orthodontia	Children: $1,975 Adults $2,175	Not covered	Not covered	Children: 60% $1,500 Lifetime max	Children: 50% $1,500 Lifetime max

The Plans At-a-Glance are intended to provide a general overview. For specific information, see Summary of Benefits & Coverages (SBCs).

VISION

OUR PLANS

VSP Choice Plan

Click to play video

Why sign up for vision coverage?

Even if you have 20/20 vision, an annual eye exam checks the health of your eyes and can detect other health issues. If you need glasses or contacts, vision coverage helps with the cost.

Visit the plan's website for extra savings on services like Glasses and Sunglasses, Routine Retinal Screening, and Laser Vision Correction.

VISION

Does not include Hourly ACA Eligible, GFFA or GPOA

	VSP Vision In-Network	Copay	Frequency
Well Vision Exam	Focuses on your eyes and overall wellness	$10 Exam and glasses	Every 12 months
Frame*	$170 featured frame brands allowance $150 frame allowance 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 Impact-resistant lenses for dependent children	Combined with exam	Every 12 months
Lens Enhancements	Standard progressive lenses Tints/Light-reactive lenses Premium progressive lenses Custom progressive lenses Average savings of 30% on other lens enhancements	$0 $0 $95 - $105 $150 - $175	Every 12 months
Contacts (Instead of glasses)	$130 allowance for contacts and contact lens exam (fitting and evaluation) 15% savings on a contact lens exam (fitting and evaluation)	$0	Every 12 months
Lightcare*	$150 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses instead of prescription glasses or contacts	Combined with exam	Every 12 months

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.

LONG-TERM DISABILITY INSURANCE

Long-term disability (LTD) insurance replaces part of your income for longer-term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

Eligibility GCEA and IBEW

LTD benefits cushion the financial impact of a disability.

The Income Protection program comprises a Core and the Buy-Up Long-Term Disability plan. You are eligible for the core Long-Term Disability plan at no cost to you. In addition, you may "Buy-Up" to the enhanced plan to provide you and your family greater protection. Offered by the Standard Insurance.

	Core Plan (Employer Paid)	Voluntary Buy-Up (Employee Paid)**
Benefit Waiting Period	60 days*	60 days*
Benefit Percentage	50%	60%
Benefit Duration	Social Security Normal Retirement Age	
Maximum Benefit	$2,500/month	$3,000/month
Costs	$0	$12/month

	Executives and GMA	Council Members
Benefit Waiting Period	60 days	60 days
Benefit Percentage	The plan replaces 66 2/3% of the first $22,500 (pre-disability) monthly earnings.	The plan replaces 66 2/3% of your first $1,500 (pre-disability) monthly earnings.
Benefit Duration	Social Security Normal Retirement Age	Social Security Normal Retirement Age
Maximum Benefit	$15,000 maximum	$1,000 maximum

*60 days or the period of salary continuation for which you are eligible under the employer's salary continuation plan, whichever is longer.
** If you were previously eligible for the buy-up and waived it, you can only elect this coverage by submitting a completed Evidence for Insurability form to Standard Insurance. Approval is subject to Standard Insurance review.

VOLUNTARY LIFE INSURANCE

GUARANTEED ISSUE

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.

Protecting those you leave behind

Voluntary life insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself. This is offered by Standard Insurance.

	The Standard Voluntary Life Insurance
Employee	$20,000 - $500,000 in increments of $20,000 Guarantee Issue: Up to $300,000
Spouse	$10,000 - $250,000 in increments of $10,000 Guarantee Issue: Up to $30,000
Child(ren)	$5,000 - $25,000 in increments of $5,000

Premium Rates	Monthly Rate/Multiple of $1,000	
Age of Insured on last January 1	**Life Insurance**	**Life Insurance for Your Spouse**
Under 30	$0.07	$0.07
30 through 34	$0.08	$0.08
35 through 39	$0.11	$0.11
40 through 44	$0.17	$0.17
45 through 49	$0.28	$0.28
50 through 54	$0.47	$0.47
55 through 59	$0.75	$0.75
60 through 64	$1.00	$1.00
65 through 69	$1.57	$1.57
70 or over	$2.77	$2.77
Life Insurance for Your Child(ren)	$0.92 monthly per $5,000 of Dependent's Life Insurance for Your Child(ren), regardless of the number covered	

TURNING 65? UNDERSTAND YOUR MEDICARE OPTIONS

Alliant
MEDICARE SOLUTIONS
A Non-Government Entity

Alliant Medicare Solutions is a no-cost service available to you, your family members, and friends nearing age 65.

alliantmedicaresolutions.com

(877) 888-0165

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

Whether you retire or continue to work, choosing the right healthcare option is an important decision when you reach the age 65

Most people become eligible for Medicare at age 65. When that happens, you'll probably have some time-sensitive decisions to make based on your individual situation.

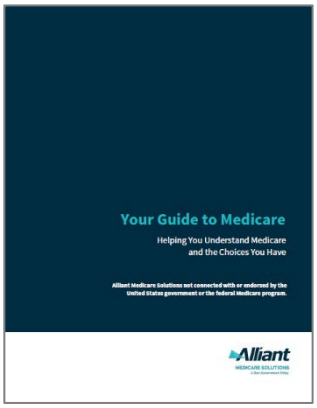
Introducing Alliant Medicare Solutions

Medicare can be complicated. Figuring out the rules—not to mention how Medicare works with or compares to your employer-provided medical coverage—can be a headache. That's why we are offering Alliant Medicare Solutions. The licensed insurance agents at AMS can help you understand Medicare, what is and isn't covered, and how to choose the best coverage for your situation.

How does it work?

1. Call Alliant Medicare Solutions at **(877) 888-0165** to speak to a licensed insurance agent. Have your current medical coverage information available when you call.
2. Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work the best for you.
3. If Medicare is the best option, Alliant Medicare Solutions helps you enroll immediately or emails policy materials for you to review and enroll at a later date.

Find Out More



Your Guide to Medicare

Medicare 101 Video

Social Security Planning Video

POTENTIAL INSURANCE COST SAVINGS

Alliant
INDIVIDUAL HEALTH SOLUTIONS

With AIHS, affordable health insurance is within reach.

Schedule an appointment at alliantindividualhealthsolutions.com or **call (877) 328-1195** to speak with a licensed insurance agent.

Your extended family and friends can also use AIHS at no charge!

Could your family get health insurance subsidies?

As part of our commitment to providing benefit options that meet your specific needs, we have partnered with Alliant Individual Health Solutions (AIHS). AIHS does not replace the company-sponsored group health insurance plans—rather, it expands options available to you and your dependents, with the opportunity for significant savings.

New rules make insurance more affordable for many

Changes in recent legislation could mean your dependents may now qualify for subsidies in the Affordable Care Act Marketplace (also called the Exchange), possibly lowering your family's healthcare premiums. The federal government has changed who may be eligible for Marketplace subsidies. If your family members previously were ineligible for Marketplace subsidies, they may now qualify.

How does it work?

The AIHS team can help you:

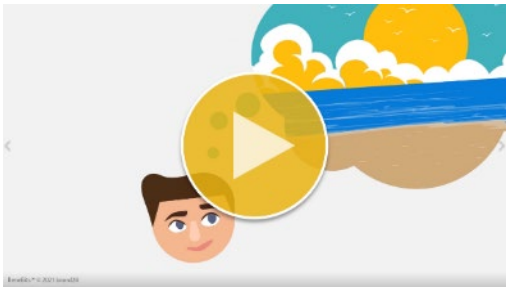
- Explore whether your dependents are eligible for subsidies.
- Learn whether an individual health plan could be a more affordable option than the company-sponsored group plans.
- Secure health coverage if you or your dependents are leaving a company plan.

AIHS may be able to help you find affordable coverage if:

- Your dependent child is turning 26 (making them no longer eligible for coverage under a company plan).
- You are retiring early (before Medicare benefits start at 65).
- Your spouse is younger than 65 (and not eligible for Medicare yet).
- You're leaving the company and want to explore options that may be more affordable than COBRA.

MISSIONSQUARE 457 DEFERRED COMPENSATION PLAN

Click to play video



MissionSquare
Contact Information
Robert Soriano
Retirement Plans Specialist
rsoriano@missionsq.org
(202) 759-7001

457 Plan Deferred Compensation Plan—up to $23,000 per year. *2024 Limit

Congratulations on starting your plan for life! The City of Glendale is pleased to offer a 457 deferred compensation plan through MissionSquare as a benefit to help you save and invest for retirement, with three great reasons to participate.

1. It's flexible — you can choose from a diverse lineup of investment options. Also, you can change how much you contribute, change your investment options, or stop contributing at any time.
2. It goes where you go — if you leave your job, you can take your vested balance with you. The contributions you make are always yours.
3. You may save money on taxes — whether you make traditional before-tax or Roth after-tax contributions, there may be tax advantages either now or later.

Online Scheduling

An ICMA representative is virtually available to assist you. Make an appointment online to see an ICMA Representative regarding your deferred compensation account: https://icmarc.secure.force.com/events?SiteId=a0lj0000003QO3LAAW.

- Click on "View Available Events".
- Click on the Date of the Individual Appointment or Seminar that you would like to attend (click the "Next" link on the upper right-hand side of the page to scroll through the events).
- Enter your Name, Phone Number, and E-mail Address.
- Select the "Yes" button to have an e-mail confirmation sent to you. Click on the "Register" button.
- Confirm the information on this screen and click "Submit."
- You will be given a confirmation number to confirm your appointment. Please hit the "Done" button at the end.

WELLBEING & BALANCE

“The key to keeping your balance is knowing when you've lost it. ”

A Happier, Healthier You

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

We offer programs to help you:

- Manage stress, substance use disorder, mental health, and family issues.
- Maximize your physical well-being.
- Take time to spend with family and friends, take care of personal business, or just for yourself.

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

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE AETNA EAP

Phone: (800) 342-8111

Website:

http://resourcesforliving.com
Login: glendaleca
Password: eap

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Aetna EAP services can help you handle a wide variety of personal issue such as emotional health and substance use disorder; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 8 visits
- Unlimited web access to helpful articles, resources, and self-assessment tools.

EMOTIONAL SUPPORT

Talk to someone about what's on your mind — stress, relationships, anxiety, depression and more. Meet face-to-face, by video stream, or get in-the-moment support by phone.

LEGAL AND FINANCIAL

Legal - Speak with an attorney for things like guidance on small claims court, family or domestic issues, and identity theft support.
Financial - Discuss budgeting, credit, and more with a financial expert.

DAILY LIFE ASSISTANCE AND ONLINE RESOURCES.

Daily life assistance - Let our specialists help you solve everyday issues and provide referrals for caregiving needs.

MEMBER WEBSITE

Check out video resources, articles assessments, webinars, podcasts and more.

IMPORTANT PLAN INFORMATION

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

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

PLAN CONTACTS

HELPFUL RESOURCES

Benefit Advocate
800-489-1390
benefitsupport@alliant.com

BENEFITS OR ENROLLING

City of Glendale
Employee Benefits
818-548-2160
Email: benefits@glendaleca.gov

MEDICAL, DENTAL & VISION

Anthem
Policy # C16244
www.anthem.com/ca
Member Services
800-288-2539

Kaiser
Policy # 118461
www. kp.org
Member Services
800-464-4000

Guardian Dental
Policy # 00385032
www.guardiananytime.com
Member Services
PPO 800-541-7846
DMO 800-459-9401

Vision Service Plan (VSP)
Policy # 30032746
www.vsp.com
Member Services
800-877-7195

PRESCRIPTION DRUGS

Anthem RX
Policy # C16244
www.anthem.com/ca
Member Services
833-261-2460

HEALTH SAVINGS ACCOUNT (HSA)

Anthem
Policy # C16244
www.anthem.com/ca
Member Services
800-288-2539

LIFE/DISABILITY

The Standard
Policy # 645178
www.standard.com
Member Services
800-628-8600

EMPLOYEE ASSISTANCE PROGRAM EAP

Aetna
www.resourcesforliving.com
Member Services
800-342-8111

FLEXIBLE SPENDING ACCOUNTS (FSA)

PayPro
www.pagroup.us
Claims: 800-427-4549
Fax: 951-346-4244
Email: claims@pagroup.us

MEDICARE

Medicare Solutions
alliantmedicaresolutions.com
Member Services
877-888-0165

INDIVIDUAL

Individual Health Solutions
alliantindividualhealthsolutions.com
Member Services
888-888-8989

CITY'S RETIREMENT PROCESS

Teri Taylan
Benefits Manager
Member Services
818-550-4403
Email: ttaylan@glendaleca.gov

MISSIONSQUARE

Robert Soriano
Retirement Plans Specialist
Email: rsoriano@missionsq.org
202-759-7001

PENSION PLANS

CalPERS
www.calpers.ca.gov
Member Services
888-225-7377

PARS-ARS
www.pars.org
Member Services
800-540-6369

GLOSSARY

-A-

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

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

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

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

-B-

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

Note: Beginning January 1, 2022 the "No Surprises Act" provides protections against surprise billing for emergency services, air ambulance services, and certain services provided by a non-participating provider at a participating facility. For these services, the member's cost are generally limited to what the charge would have been if received in-network, leaving any balance to be settled between the insurer and the out-of-network provider. Consult your health plan documents for details.

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

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

-C-

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

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

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

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

-D-

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

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

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

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

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

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

-E-

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

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

-F-

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

-G-

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

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

-H-

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

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

GLOSSARY

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

-I-

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

-L-

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

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

-M-

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

-O-

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

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

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

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

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

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

-P-

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

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

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

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

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

-S-

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

-T-

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

-U-

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

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

-V-

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

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

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located below.

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

COBRA CONTINUATION COVERAGE

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

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- The City of Glendale Group Health Plan

SUMMARY OF BENEFITS AND COVERAGE (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available.

- Anthem HMO, PPO, HDHP
- Kaiser HMO

STATEMENT OF MATERIAL MODIFICATIONS

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

Medicare Part D Notice

Important Notice from City of Glendale About
Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of 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:

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

2. The City of Glendale has determined that the prescription drug coverage offered by the City of Glendale 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 City of Glendale coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

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

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with 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 (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through 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'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	June 1, 2024
Name of Entity/Sender:	City of Glendale
Contact-Position/Office:	Human Resources/Benefits
Address:	613 E. Broadway, Suite 100
Phone Number:	818-548-2160

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call health plan's Member Services for more information.

Newborns' and Mothers' Health Protection Act

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

Availability of Privacy Practices Notice

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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 of your modified adjusted household income.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in the City of Glendale health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in the City of Glendale health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the City of Glendale health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

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

Notice of Choice of Providers

The City of Glendale allows 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. For information on how to select a primary care provider and for a list of the participating primary care providers, contact the plan administrator.

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

You do not need prior authorization from the City of Glendale or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare 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 healthcare professionals who specialize in obstetrics or gynecology, contact the plan administrator.

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility—

ALABAMA – Medicaid

Website: http://myalhipp.com/ | Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ | Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/ | Phone: 1-855-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 (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991 | State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

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: 1-877-438-4479
All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx | Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html | Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare | Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov | Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov | Phone: 1-888-828-0059

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or
https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/

Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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