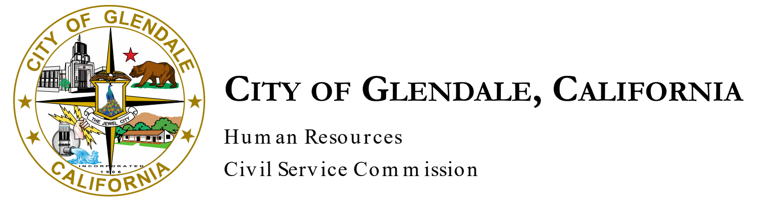
Ready, Set, Enroll!

City of Glendale 2024-2025 Retiree Benefits



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

May 08, 2024

Dear Retiree,

I hope this letter finds you well. I am writing to notify you of the upcoming Open Enrollment period, as well as other pertinent information related to your benefits.

As you are already aware, PayFlex changed their name to ***Inspira Financial*** during our current benefit plan year. In addition, the City recently changed our insurance broker from Keenan & Associates to ***Alliant Insurance Services***.

Cost management of our health benefits program continues to be a top priority. As health care costs continue to increase nationwide, we unfortunately received increases in the retiree plans this year for both Anthem and Kaiser. *The new insurance renewal rates are included in the Benefits Guide.*

We hope you will take the time to review the options provided in the Benefits Guide to make the decisions that will best serve your healthcare needs. This guide provides information for the 2024-25 City of Glendale Open Enrollment period for the City's Retiree medical, dental and vision plans.

This letter addresses the following items:

- Open Enrollment Period **May 10, 2024 through May 24, 2024** - ***Renewals effective June 1, 2024***
  - *Please note: If you are NOT making changes, you do not need to do anything.*
  - *If you do wish to make any changes, please contact Benefits at 818-548-2160 immediately, to obtain the necessary forms.*
- Mail-in Prescription Benefit
- Retirees or Spouses/Dependents Becoming Medicare Eligible in 2024-2025

Open Enrollment – May 10, 2024 – May 24, 2024

As a City of Glendale retiree, you may use the Open Enrollment period as an opportunity to make changes to your current benefits. *Any changes will take effect June 1, 2024*. The new Benefits Guide can also be found online at https://www.glendaleca.gov/government/departments/human-resources/benefit-information/retirees.

During open enrollment, retirees currently enrolled in one of the City medical plans can switch from one plan to another, if desired. Medicare Retirees may also wish to consider looking into coverage with Alliant Medicare Solutions which will be available during their October – December open enrollment period.

Important: If you wish to cancel any of your benefits at any time with the City, you must notify Benefits at 818.548.2160 *prior to the effective date of termination of coverage*, by completing the declination form enclosed. It can be scanned and emailed to **Benefits@glendaleca.gov**. We must have the Benefit Waiver form in *advance,* in order to cancel your coverage with Inspira Financial (formerly PayFlex).

Mail-in Prescription Benefit
As a reminder, if you are on maintenance prescriptions, you may be interested in using the mail-in pharmacy where you can receive a 90-day prescription refill generally for the cost of a 30-day prescription from a pharmacy. Information regarding this program is provided in the Benefits Guide.

Important Notice for Retirees or Dependents Becoming Eligible for Medicare Part A and B in 2024-25
A retiree and/or dependent (spouse, domestic partner or child) who is eligible for Medicare coverage by reason of age or disability *must be enrolled in Medicare Part A (Hospital Insurance) and Part B (Medical Insurance)* to maintain their eligibility with the City of Glendale's retiree medical coverage (as well as most other medical insurance providers).

Once a covered member becomes eligible for Medicare, they must enroll in Medicare through www.Medicare.gov three months prior to their 65th birthday with coverage becoming effective the first of the month in which they turn 65 or become eligible.

> If a retiree and/or qualified dependent enroll in Medicare Part A and are not eligible to receive Part A for free, the City will reimburse the cost of their Part A Medicare premium, provided that the invoice is emailed to payroll@glendaleca.gov *every month* so the reimbursements can be processed.

Alliant Medicare Solutions can assist you with reviewing options and enrolling in Medicare supplemental coverage. ***Alliant Individual Health Solutions*** can assist you with reviewing options and enrolling in early retiree (*Pre-Medicare*) medical coverage outside of the City's retiree plans.

Special Medicare Premium Notice: *If Medicare does not receive your premiums on time, they will notify the carrier that you no longer have Medicare Part A and/or Part B coverage. When the carrier receives this information, your medical coverage through the City will also be cancelled. To avoid this issue, you must always pay your Medicare premiums timely.*

If you should have any questions or if you are making any changes, please feel free to contact us at 818.548.2160 or Benefits@glendaleca.gov.

Sincerely,

Teri Taylan
Benefits Manager

cc: Paula Adams, Chief Human Resources Officer

MissionSquare RHSP - Modifying the New Rates for Reimbursement

To modify the automatic reimbursement for your insurance premiums with MissionSquare, retirees may complete and submit the enclosed Benefits Reimbursement Request Change Form and fax it along with the new invoice to 888-665-8495. The request may also be filed on the Meritain Health claims portal via account access at www.missionsq.org/login -> select RHSP -> Benefits Reimbursements (this will take you to the Meritain Claims Portal where you can change or setup your reimbursement request and submit your new invoice from Inspira Financial).

Benefits - Open Enrollment Support / Benefits Inquiry / Eligibility / Claim Issues / Changes

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

Phone: 818-548-2160 | Hours: 8:00am – 5:00pm | Email: Benefits@glendaleca.gov
Fax: 818-243-8428

Inspira Financial – City of Glendale Retiree Billing for Medical, Dental, Vision, & Life Plans

Phone: 800-359-3921 | Hours: 8:00am – 7:00pm (CT) | Website: www.inspirafinancial.com

Alliant Insurance Services – Alliant Medicare Solutions

Alliant Medicare Solutions | Hours: 8:00am – 5:00pm | Website: www.alliantmedicaresolutions.com
Phone: 877-888-0165

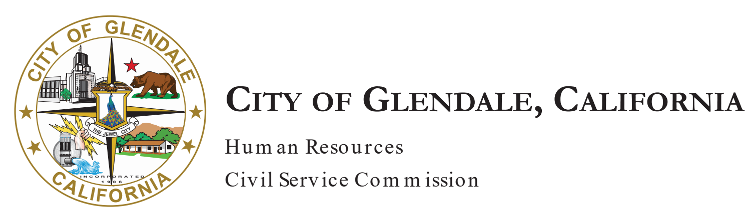
Alliant Individual Health Solutions | Hours: 8:00am – 6:00pm | Website: www.alliantindividualhealthsolutions.com
Phone: 888-888-8989

MissionSquare Deferred Compensation Plan / Meritain Health - RHSP Reimbursements

Balances 800-669-7400 | Reimbursements 888-587-9441 | Website: www.missionsq.org/login
Hours 8:30am – 9:00pm (ET) | Hours 8:00am – 5:00pm (ET) | Fax 888-665-8495

Medicare Part A Reimbursements – (You can fax or email your Medicare invoice to Payroll or Benefits.)

Phone: 818-548-2106 | Hours: 8:00am – 5:00pm | Email: Payroll@glendaleca.gov
Fax: 818-551-6923



613 E. Broadway, Suite 100
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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.

2024-25 Monthly Rates: Retirees

EFFECTIVE JUNE 1, 2024 - MAY 31, 2025

ANTHEM BLUE CROSS - California Retirees

	Total Monthly Premium with Medicare	Total Monthly Premium without Medicare
Single	$435.19	$1,704.39
Two-Party (1 Medicare)	$2,139.58	$4,363.16
Two-Party (2 Medicare)	$870.38	N/A
Family (1 Medicare)	$4,798.35	$6,187.04
Family (2 Medicare)	$1,305.57	N/A

ANTHEM BLUE CROSS - Out-Of-State Retirees Only

	Total Monthly Premium with Medicare	Total Monthly Premium without Medicare
Single	$435.19	$1,728.52
Two-Party (1 Medicare)	$2,163.71	$4,424.73
Two-Party (2 Medicare)	$870.38	N/A
Family (1 Medicare)	$4,859.92	$6,274.18
Family (2 Medicare)	$1,305.57	N/A

ANTHEM HIGH DEDUCTIBLE HEALTH PLAN - Early Retirees Only

	Total Monthly Premium without Medicare
Single	$1,460.51
Two-Party	$3,067.06
Family	$4,381.49

ANTHEM BLUE CROSS - California Care HMO - California Retirees

	Total Monthly Premium with Medicare	Total Monthly Premium without Medicare
Single	$509.84	$1,443.35
Two-Party (1 Medicare)	$1,953.19	$3,030.97
Two-Party (2 Medicare)	$1,019.68	N/A
Family (1 Medicare)	$3,396.20	$4,329.69
Family (2 Medicare)	$1,529.52	N/A

2024-25 Monthly Rates: Retirees EFFECTIVE JUNE 1, 2024 - MAY 31, 2025

KAISER PERNAMENTE HMO - California Retirees

	Total Monthly Premium with Medicare	Total Monthly Premium without Medicare
Single	$182.61	$1,442.59
Two-Party (1 Medicare)	$1,625.20	$2,885.18
Two-Party (2 Medicare)	$365.22	N/A
Family (1 Medicare)	$2,822.55	$4,082.53
Family (2 Medicare)	$1,562.57	N/A

KAISER PERNAMENTE DEDUCTIBLE HMO - California Early Retirees Only

	Total Monthly Premium without Medicare
Single	$1,195.69
Two-Party	$2,391.39
Family	$3,383.81

GUARDIAN DENTAL

	High Option PPO (*only with Anthem PPO)	Buy-Up PPO	MDC-G90 DMO
Single	$44.84	$36.82	$18.36
Two-Party	$76.22	$62.56	$33.63
Family	$116.57	$95.71	$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
					$
					$
					$

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

Total reimbursement request: $ 0.00

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.*

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:

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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

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.

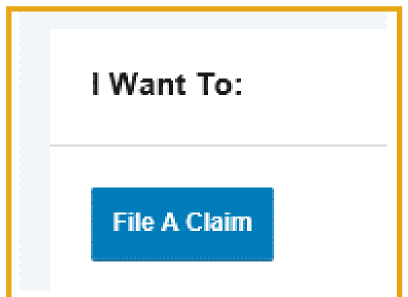
Common examples include:

- 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***

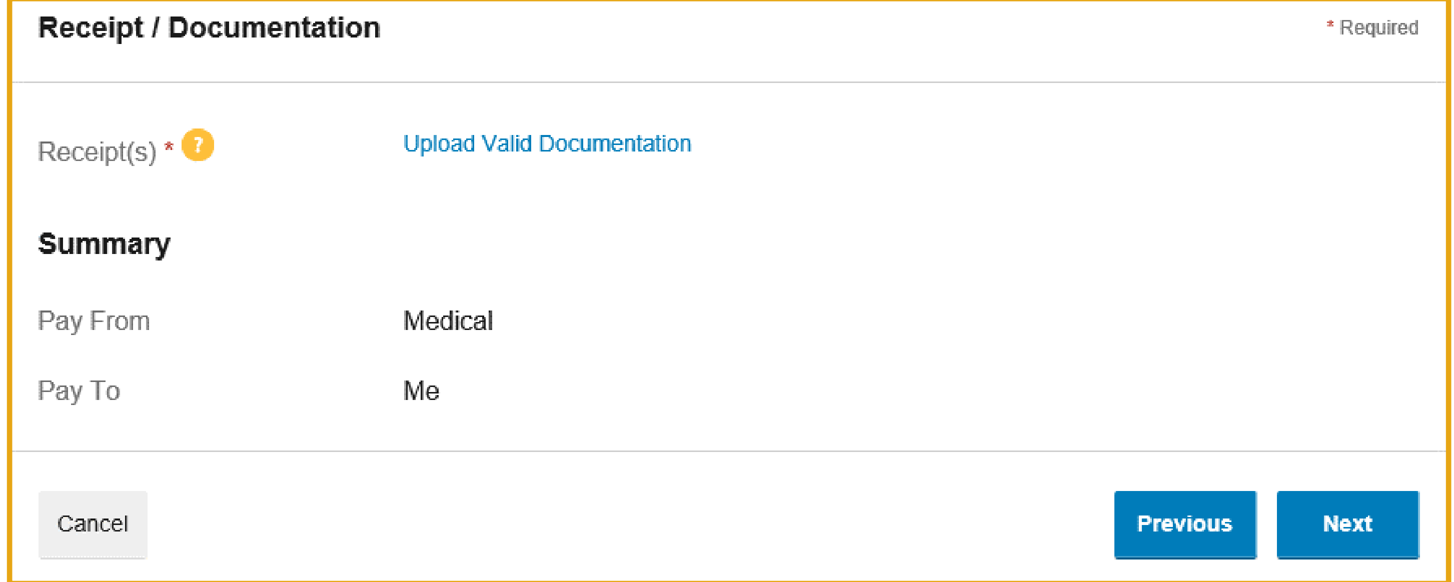
Step 2

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



Step 3

You will be prompted to upload your supporting documents.

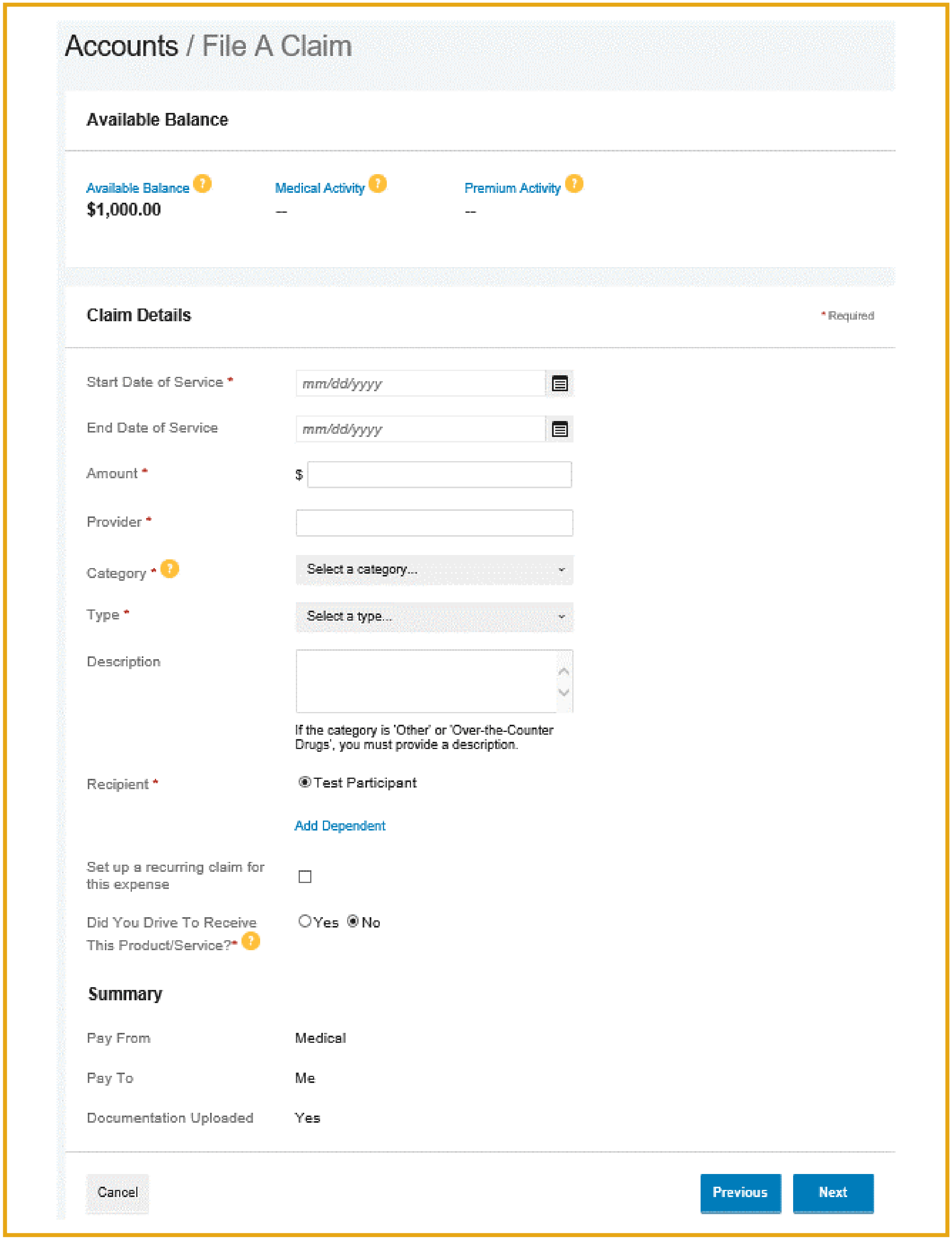


Step 4

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

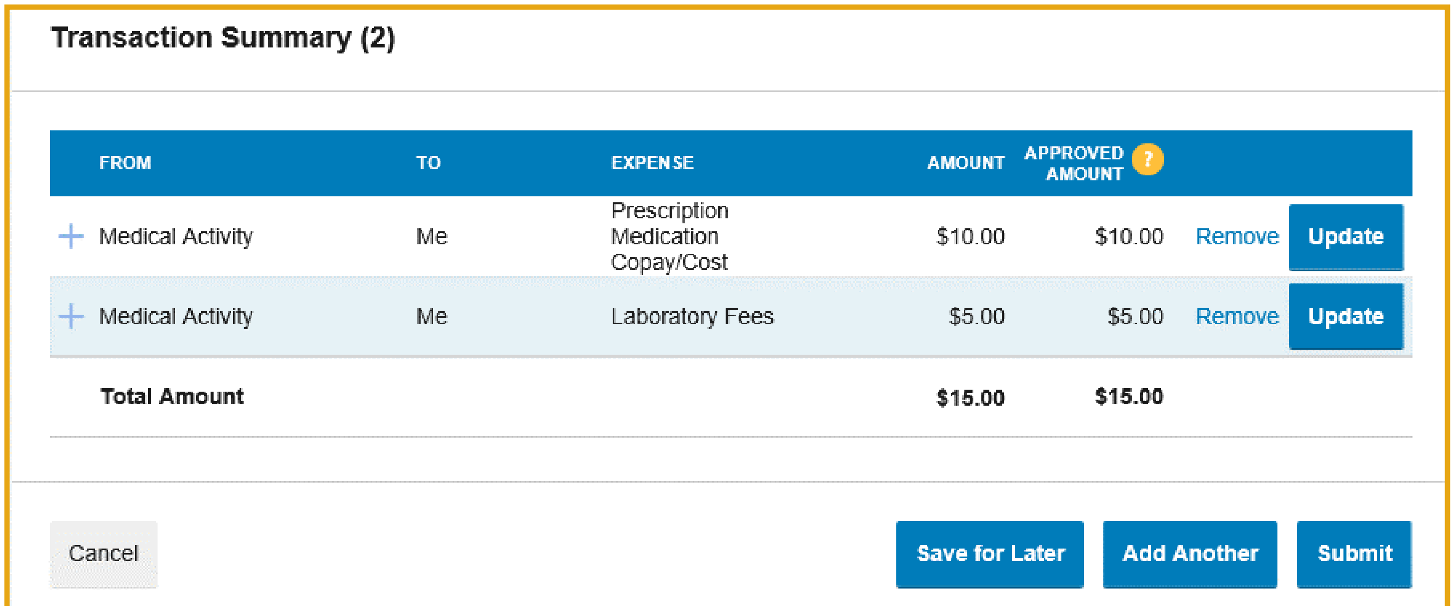
- Date of service
- Amount
- Provider
- Category and claim type
- Recipient (select dependent if applicable)

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.



Transaction Summary (2)

FROM	TO	EXPENSE	AMOUNT	APPROVED AMOUNT		
Medical Activity	Me	Prescription Medication Copay/Cost	$10.00	$10.00	Remove	Update
Medical Activity	Me	Laboratory Fees	$5.00	$5.00	Remove	Update
Total Amount			**$15.00**	**$15.00**		

Cancel | Save for Later | Add Another | Submit

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

www.meritain.com | © 2021–2022 Meritain Health, Inc.

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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

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.

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.

WHO'S ELIGIBLE FOR BENEFITS?

City of Glendale Retirees

As a City of Glendale Retiree, you may be eligible for retiree health benefits.

Eligible dependents

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

- Your legal spouse or domestic partner, if you are legally registered with the State of California and have a complete and notarized Declaration of Domestic Partnership Affidavit.
- Your dependent children who are under age 26

Important Notes About Dependent Eligibility

- 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 Retiree health benefits.
- 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).

What To Do Now

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

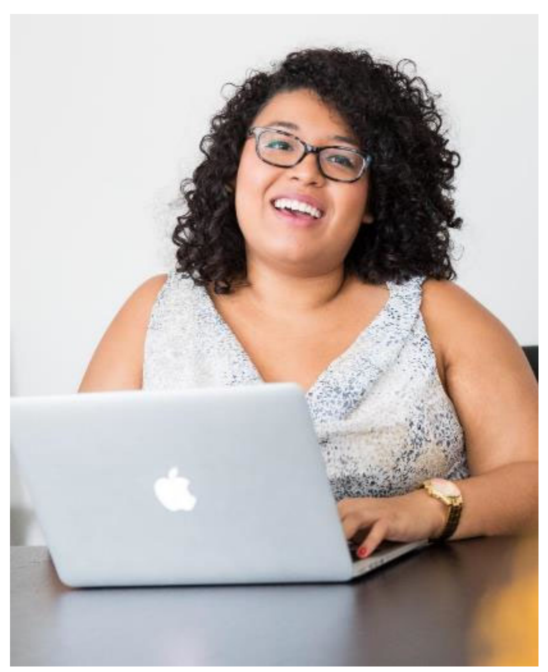
Making Changes to Your Benefits

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

Questions call Benefits at (818) 548-2160

Email: benefits@glendaleca.gov

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



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.
Open Enrollment (mid-April through early May) use this opportunity to make changes to your current medical, dental, and vision insurance elections.

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. Dependents will lose coverage the first of the month following the loss of eligibility. If divorced, you must notify the city within 30 days of the final divorce date. You must add your dependents within 30 days of the qualifying event. (marriage, birth, etc.)

CITY'S GUIDELINES FOR RETIREES

Medical Guidelines and Provisions

- Active employees, upon retirement, will be eligible to participate in the Retirement Medical Programs to which they belong at the time of retirement.
- Retiree plan benefits are similar to those for active employees.
- A retiree 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 for 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 on the 1st of the month of the retiree's 65th birthday.
- If a retiree and/or qualified dependent enrolls in Medicare Part A (Hospital Insurance) and does not qualify for Part A for free, the City will reimburse the cost of their Medicare Part A (Hospital Insurance) premium.
- Retirees eligible for Medicare Part A reimbursement must submit their Medicare Part A invoice on a monthly basis. There will be no retroactive reimbursements.
- Retirees and/or qualified dependent who are within three months of turning age 65, must contact Medicare at www.medicare.gov to apply for **Part A (Hospital Insurance) and Part B (Medical Insurance)** to enroll no later than the first of the month in which they turn age 65. If they wish to enroll in the City's Medicare plan, they will need to contact Benefits@glendaleca.gov to obtain information to assist in the enrollment process for their new secondary coverage.
- Retirees may add new dependents after retirement (consistent with the plan terms and contracts).
- The spouse or domestic partner of a deceased retiree may remain on the insurance plan after the death of the retiree, subject to plan restrictions and requirements.
- Retirees 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 who were on the retiree medical plan as of August 1, 2015, unless they were removed due to non-payment of premiums.)
- Retirees who are married to one another have specific eligibility requirements. When one is a retiree and is in a dependent status on the other's insurance, the dependent retiree 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.

CITY'S GUIDELINES FOR RETIREES (CONTINUED)

Dental and Vision Guidelines and Provisions

- Dental and Vision coverage may be continued with the City, with the retiree responsible for paying the full premium.
- Retirees may add new dependents after their retirement (consistent with the plan terms and contracts) provided they have not previously been a dependent during the retiree's retirement.
- The spouse or domestic partner of a deceased retiree may remain on the insurance plan after the death of the retiree (subject to plan restrictions and requirements).
- Retirees 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

- Executive, Management, and Mid-Management employees with 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.
- Retirees 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**.

Billing Services

The City of Glendale utilizes Inspira Financial (formerly PayFlex) as our TPA (third-party administrator) to manage the City's Retiree Billing Services. As the Billing Administrator for the City, Inspira Financial 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 Inspira, invoices will be available on your customer portal at www.inspirafinancial.com The invoice will provide the cost of your benefit election. Please remember your payment is always due by the 1st of the month for that months' coverage.

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.

Inspira Financial Health, Inc.
Benefit Billing Department
P.O. Box 953374
St Louis, MO 63195-3374

If you have any questions, please contact Inspira at **(800) 359-3921** for customer service. You can access your account online at www.inspirafinancial.com.

Inspira is unable to make any changes to your benefits or contact information without 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 Section 613 E. Broadway, Suite 100 Glendale, CA 91206
Email: benefits@glendaleca.gov

WHICH PLAN IS RIGHT FOR YOU?

All about PPO 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.

Plans To Consider

- Anthem HMO Plan
- Kaiser Traditional HMO Plan
- Kaiser Deductible HMO Plan
- Anthem Senior Secure HMO (Medicare)
- Anthem Medicare Advantage Plan (Medicare) is available for retirees living out of state.
- Kaiser Senior Advantage HMO (Medicare)

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
- Anthem Blue Card Network PPO (Plan available to retirees living out of state, Non-Medicare participants)

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 (available to retirees living out of state, Non-Medicare participants)

MEDICAL

OUR PLANS EARLY RETIREE

- Anthem PPO 80/60
- Anthem PPO HDHP/HSA
- Anthem HMO
- Kaiser Traditional HMO
- Kaiser Deductible HMO

MEDICARE

- Anthem Medicare Advantage Plan (MAPD)
- Anthem Senior Secure HMO
- Kaiser Senior Advantage HMO

OUT OF STATE Non-Medicare

- Anthem Blue Card Network PPO
- Anthem High Deductible Plan

OUT OF STATE Medicare

- Anthem Medicare Advantage Plan (MAPD)

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.

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

ANTHEM PPO-EARLY RETIREE (UNDER 65)

	Anthem PPO – Prudent Buyer		Anthem 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 EARLY RETIREE (UNDER AGE 65)

	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).

ANTHEM AND KAISER HMO AND PPO PLANS RETIREE (AGE 65 AND OVER)

	Anthem Medicare HMO Plan 3	Anthem Medicare PPO 10PL	Kaiser Senior Advantage HMO
	In-Network	In-Network & Out-of-Network	In-Network
Annual Deductible	Individual: $ 0	Individual: $100	None
Annual Out-of-Pocket Maximum	$3,400	$3,400 combined in and out of network	$1,000 per year per member
Office Visit	No copay	$10 copay $25 copay for specialist	$10 copay $10 copay for specialist
Online Visit	No copay	$10 copay $25 copay for specialist	No charge
Chiropractic	$5 (12 visits per year)	$20 copay	$10 per visit
Lab and X-ray	No copay		No charge
Urgent Care	No copay	$25 copay	$10 per visit
Emergency Room	$20 visit (waived if admitted)	$75 copay	$50 per visit
Hospitalization	No copay	$300 copay	$200 per admission
Outpatient Surgery	No copay	$100 copay	$10 per procedure
PRESCRIPTION DRUGS			
Deductible	None	None	None
Out-of-Pocket Maximum	None	None	None
Generic	$7 copay (for 30 days)	$10 copay (30 days)	$10 for up to a 100-day supply
Brand Name	$7 copay (for 30 days)	$20 copay (30 days)	$25 for up to a 100-day supply
Mail order	$15 copay (90 days)	$10 / $20 (90 days)	$10 / $25 (100 days)

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

OUT-OF-STATE PLANS

ANTHEM NON-MEDICARE PPO (UNDER AGE 65)

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

	Anthem Blue Card 80/60		Anthem 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	Individual: $4.500 Member: $4,500 Family: $9,000
Annual Out-of-Pocket Maximum	Individual: $2,000 Family: $0	Individual: $4,000 Family: $0	Individual: $4,000 Member:$4,000 Family: $8,000	Individual: $9,000 Member: $9,000 Family: $18,000
Office Visit	$20 copay $20 copay for specialist	40%	20% 20% for specialist	40%
Online Visit	No charge	No charge	20%	40%
Chiropractic	20%	40%	20%	40%
Lab and X-ray	20%	40%	20%	40%
Urgent Care	$20 copay	40%	20%	40%
Emergency Room	20%	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 In-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	**Lowest cost generic** $5 copay. (retail) and $10 copay (home delivery). **Generic** $15 copay (retail) and $30 (home delivery)	40% up to $250
Brand Name	Preferred: $20 Non-Preferred $20 (retail and home delivery)	50% up to $250	**Preferred**: $40 copay (retail) and $100 copay (home delivery) **Non-Preferred**:$60 copay (retail) and $180 copay (home delivery)	40% up to $250
Specialty	$20 copay (retail and home delivery) brand and generic	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 days Home delivery – 90 days	Retail – 30 days Home delivery – 90 days	Retail – 30 days Home delivery – 90 days	Retail – 30 days Home delivery – 90 days

OUT-OF-STATE PLANS
ANTHEM MEDICARE PPO (OVER AGE 65)

	Anthem Medicare PPO 10PL
	In-Network & Out-of-Network
Annual Deductible	Individual: $100
Annual Out-of-Pocket Maximum	$3,400 combined in and out of network
Office Visit	$10 copay $25 copay for specialist
Online Visit	$10 copay $25 copay for specialist
Chiropractic	$20 copay
Lab and X-ray	
Urgent Care	$25 copay
Emergency Room	$75 copay
Hospitalization	$300 copay
Outpatient Surgery	$100 copay
PRESCRIPTION DRUGS	
Deductible	None
Out-of-Pocket Maximum	None
Generic	$10 copay (30 days)
Brand Name	$20 copay (30 days)
Mail order	$10 / $20 (90 days)

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

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.

1 Prescription availability is defined by physician judgment and state regulations. Visit the home page of livehealthonline.com to view the service map by state.

2 Appointments subject to availability of a therapist.

LiveHealth Online is the trade name of Health Management Corporation, a separate company providing telehealth services on behalf of Anthem Blue Cross. 60019CAMENABC_MP VPCD 06/17

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[SM] 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.

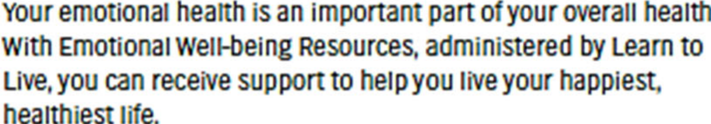
Download our Sydney Health app today!

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

1 Appointments subject to availability of a therapist.

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.

Learn to Live, Inc. is an independent company offering online tools and programs for behavioral health support. Learn to Live is an education program and should not be considered medical treatment.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

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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

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.

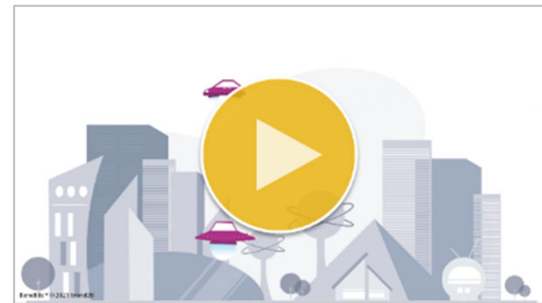
Choose from thousands of on-demand workout videos and get reduced rates on livestream and in-person classes.

KNOW WHERE TO GO

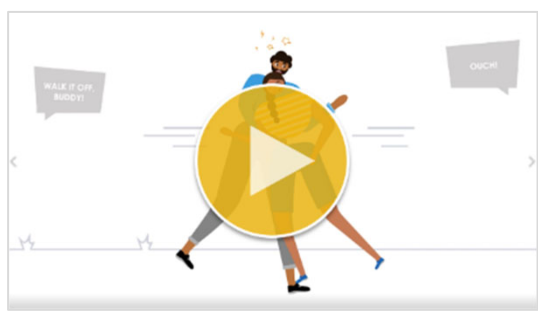
Where you get medical care can significantly influence the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

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

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.

TYPICAL SCREENINGS FOR ADULTS

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

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

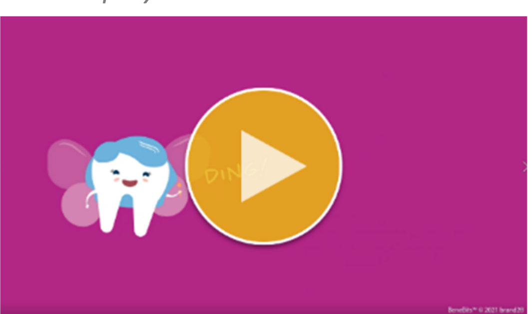
Guardian MDC-G90 DMO

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

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 only applies to retirees who qualify per their Associations' Memorandum of Understanding (MOU) at retirement.

	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	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

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

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

	VSP Vision	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 Premium progressive lenses Custom progressive lenses Average savings of 30% 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) 15% savings on a contact lens exam (fitting and evaluation)	$0	Every 12 months
Extra Savings	**Glasses and Sunglasses** Extra $20 to spend on featured frame brands. Go to **vsp.com/offers** for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Routine 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.		

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

TURNING 65? UNDERSTAND YOUR MEDICARE OPTIONS

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.

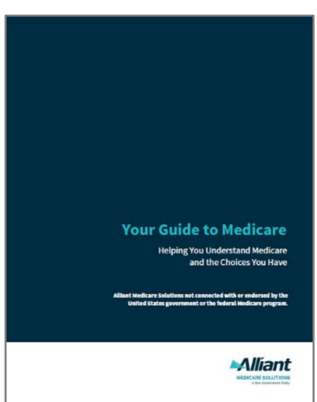
Introducing Alliant Medicare Solutions

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

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.

PLAN CONTACTS

HELPFUL RESOURCES

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

BENEFITS OR ENROLLING

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

MEDICAL, DENTAL & VISION

Anthem
Policy # C16244
www.anthem.com
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

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.

-

GLOSSARY

-E-

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

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

-F-

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

-G-

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

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

-H-

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

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

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

-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.

-

GLOSSARY

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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CITY OF GLENDALE
CALIFORNIA
THE JEWEL CITY