

2020



RETIREE  
BENEFITS  
GUIDE



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

Please see page 35 for more details.

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

# General Information

## Introduction

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### Annual Open Enrollment

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

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

### Important Dates

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

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

### What To Do Now

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

### Making Changes to Your Benefits

If you are adding / removing dependents from coverage, or changing your coverage, Enrollment and Change Forms are available in the Benefits Department.

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

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

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



# Introduction (continued)

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## IRS Guidelines

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

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

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

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

### REMOVING DEPENDENTS

The effective date used when you remove a dependent will be the first of the month following the date of notification to the City.

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

### ADDING DEPENDENTS

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

# Eligibility

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

## Employee Eligibility

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

## Dependent Eligibility

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

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

## Over-Age Dependents

Health care reform legislation has mandated that group health plans (Anthem Blue Cross Prudent Buyer / CaliforniaCare, Kaiser Permanente, Guardian, and Vision Service Plan) offer coverage to dependent children until they attain age 26.

## Important Notes About Dependent Eligibility

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



# Health Plan Options

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## Plans Available for Retirees Living in California

### Non-Medicare Participants

- Anthem Blue Cross Prudent Buyer PPO 80/60 Plan
- Anthem Blue Cross CaliforniaCare HMO
- Kaiser Permanente Traditional HMO
- Kaiser Permanente Deductible HMO
- KeenanDirect

### Medicare Participants

- Anthem Blue Cross Prudent Buyer PPO 80/60 Plan
- Anthem Blue Cross Senior Secure HMO
- Kaiser Senior Advantage HMO
- Futuris Medicare Exchange

## Plans Available for Retirees Living Out-of-State

### Non-Medicare Participants

- Blue Card Network PPO 80 / 60 Plan

### Medicare Participants

- Fee for Service 80 Plan
- Futuris Care / Medicare Exchange

## Futuris Care for Medicare Retirees

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

- Open enrollment dates are October to December for a January 1 effective date.
- Online information and enrollment can be accessed through the website at [www.medicare.healthcompare.com/futuriscare](http://www.medicare.healthcompare.com/futuriscare). The website has the ability for you to enter your current prescription drugs you are taking and it will search the plans that cover your prescriptions.
- If you would prefer to contact a Benefit Advisor on your own you may do so at 888.616.7130, Monday through Friday, 6:00 AM to 6:00 PM, and they can do the same search on your behalf. Please make sure you tell the benefit advisor that you retired from the City of Glendale to ensure they have added the correct affiliation.
- **Possible Premium Savings:** Although premiums vary depending on your age, gender, and zip code, the average premium for retirees from the City of Glendale who enrolled in a Futuris Care plan is approximately \$220.

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

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

### Everyone Will Need Health Insurance

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

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

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

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

### Individual and Family Plans

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

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

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

### About KeenanDirect

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

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

# How Health Plans Work

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## Preferred Provider Organization (PPO) Plans

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

### Anthem Blue Cross Prudent Buyer PPO 80 / 60 Plan – Medicare and Non-Medicare

- Each time you need care, you can choose an in-network (PPO) or out-of-network (non-PPO) provider. Provider directories are available at the Anthem Blue Cross website [www.anthem.com/ca](http://www.anthem.com/ca).
- When you see a PPO provider, simply present your ID card at your appointment and pay a \$20 office co-payment.
- When your health care is not an office visit, your provider files the paperwork for your claim and you receive a bill in the mail for your deductible and / or coinsurance amount, usually 20% of the cost of most in-network covered services.
- When you see a non-PPO provider, you generally pay the out-of-network deductible, 40% of the cost for most covered services and the excess amount. In some instances, the provider might have you pay up-front.
- The PPO plan does pay 100% of eligible health care expenses once the member reaches the annual out-of-pocket maximum, which is In-Network: \$2,000 / Out-of-Network \$4,000 (100% of what is considered reasonable and customary; member responsible for the excess charges).
- When medication is prescribed, you must fill the prescription with a contracted retail pharmacy. You will pay the following:
  - **Retail Prescription**  
**Generic:** \$10 (30-day supply)  
**Brand:** \$20 (30-day supply)
  - **Mail Order Prescription**  
**Generic:** \$10 (90-day supply)  
**Brand:** \$20 (90-day supply)
- **Coordinating Benefits with Medicare.** Anthem Blue Cross will not provide benefits under this plan that duplicate any benefits to which you would be entitled under Medicare. This exclusion applies to all parts of Medicare in which you can enroll without paying an additional premium. If you are required to pay an additional premium for any part of Medicare, this exclusion will apply to that part of Medicare only if you are enrolled in that part.
- If you are entitled to Medicare, your Medicare coverage will not affect the services covered under this plan except as follows:
  - Medicare must provide benefits first to any services covered both by Medicare and under this plan.
  - For services you receive that are covered both by Medicare and under this plan, coverage under this plan will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.
  - For any given claim, the combination of benefits provided by Medicare and the benefits provided under this plan will not exceed covered expenses for the covered services.
- Anthem Blue Cross will apply any charges paid by Medicare for services covered under this plan toward your plan deductible.

# How Health Plans Work (continued)

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## Anthem Blue Card Network PPO 80 / 60 Plan Non-Medicare

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

### Retail Prescription

**Generic:** \$10 (30-day supply)

**Brand:** \$20 (30-day supply)

### Mail Order Prescription

**Generic:** \$10 (90-day supply)

**Brand:** \$20 (90-day supply)

## Fee-for-Service – Medicare

- When you see a provider, simply present your ID card at your appointment. Your provider files the paperwork for your claim and you receive a bill in the mail for your deductible and/or coinsurance amount, usually 20% of the cost for most covered services and the excess amount. In some instances, the provider might require payment up-front.
- After you incur \$3,000 single/\$6,000 family in covered expenses during a calendar year, you will no longer pay copays for the remainder of the year. You will, however, remain responsible for the deductibles, for costs in excess of the covered expense, and for non-covered expenses.
- When medication is prescribed, you must fill the prescription with a contracted retail pharmacy. You will pay the following:

### Retail Prescription

**Generic:** \$10 (30-day supply)

**Brand:** \$20 (30-day supply)

### Mail Order Prescription

**Generic:** \$10 (60-day supply)

**Brand:** \$20 (60-day supply)

- **Coordinating Benefits with Medicare.** When you incur covered expenses under this plan, Anthem Blue Cross will determine their payment and then subtract the amount of your benefits available from Medicare Parts A & B. Anthem Blue Cross will pay the amount that remains after subtracting Medicare's benefits.

Anthem Blue Cross will apply this method of payment when you are retired and eligible to enroll in Medicare Part A or B, and whether or not benefits to which you are entitled are actually paid by Medicare.

**For example:** Say you are billed for \$100 of covered expense, and in the absence of Medicare, Anthem Blue Cross would pay \$80. If Medicare pays \$50, Anthem Blue Cross would subtract that amount from the \$80 and pay \$30. However, if in this same example, Medicare's payment is \$80 or more, Anthem Blue Cross will not pay a benefit. Any combination benefit from Medicare and this plan will equal, but not exceed, what Anthem Blue Cross would have paid if you were not eligible for Medicare.

# How Health Plans Work (continued)

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## HMO Plans

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

### Anthem CaliforniaCare and Kaiser Permanente – Non-Medicare

- No deductibles
- Minimal copays for certain services (e.g., doctor's office visit - \$10 copay)
- No charge for approved hospital stays
- No claim forms
- Covered preventive services such as annual physicals, well-baby and well-woman care and immunizations
- When medication is prescribed, you must fill the prescription at a contracted retail pharmacy. You will pay the following copay:
  - Anthem CaliforniaCare**  
Generic: \$5 (30-day supply)  
Brand: \$10 (30-day supply)
  - Kaiser Permanente**  
Generic: \$5 (100-day supply)  
Brand: \$10 (100-day supply)

### Kaiser Permanente Deductible HMO - Non-Medicare

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

### Anthem Blue Cross Senior Secure and Kaiser Senior Advantage – Medicare

- No deductibles
- Minimal copays for certain services (e.g., doctor's office visit - \$10 copay)
- No charge for approved hospital stays
- No claim forms
- Covered preventive services such as annual physicals, well-baby and well-woman care and immunizations
- Covered vision benefits for routine exams and lens/frames benefits
- **Anthem Blue Cross Senior Secure:** covered dental care for preventive care and restorative services
- When medication is prescribed, you must fill the prescription at a contracted retail pharmacy. You will pay the following copay:
  - Anthem Blue Cross Senior Secure**  
\$7 (30-day supply)
  - Kaiser Senior Advantage**  
Generic: \$10 (100-day supply)  
Brand: \$25 (100-day supply)

# Health Plan Decision Guidelines

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It is important to review the Health Plans At-A-Glance comparison charts starting on page 11 for help in picking the right health plan.

## How Do I Compare Health Plans?

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

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

## Things to Consider

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

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



## Core Benefits

# Medical Benefits – California PPO Plans

### Non-Medicare and Medicare

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

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

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

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

# California PPO Plans (continued)

## Non-Medicare and Medicare

Summary of Services	www.anthem.com/ca Anthem Blue Cross PPO 80 / 60 Plan	
	In-Network Benefits	Out-of-Network Benefits
<b>Outpatient Hospital *</b>		
• Outpatient Surgery	No copay (deductible waived)	40% (limited to \$350 / day)
• Mental or Nervous Disorders	20%	40%
• Acute Alcoholism or Drug Dependence	20%	40%
<b>Maternity</b>		
• Prenatal Care	\$20	40%
• Postnatal Care	20%	40%
• Hospital Charges	20%	40%
<b>Prescription</b>		
• Generic	\$10 (30 days)	
• Brand	\$20 (30 days)	
• Mail Order Prescription Drugs	\$10 / \$20 (90 days)	
• Oral Contraceptives	Yes	

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

### Hospital Quality Comparison

If you are interested in comparing hospitals in your area, visit [www.healthcompare.com/futuriscare](http://www.healthcompare.com/futuriscare).

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

# California HMO Plans

## Non-Medicare

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

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

# California HMO Plans (continued)

## Non-Medicare

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

\* Pre-authorization required for facility-based care

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

# California HMO Plans (continued)

## Medicare

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

Summary of Services	www.anthem.com/ca	www.kp.org
	Anthem Blue Cross Senior Secure HMO In-Network Benefits Only	Kaiser Senior Advantage HMO In-Network Benefits Only
<b>Maximum Lifetime Benefit</b>	Unlimited	Unlimited
<b>Annual Out-of-Pocket Maximum</b>		
• Member	N/A	\$1,500
• Family	N/A	\$3,000
	<b>MEMBER COPAY</b>	
<b>Preventive Services</b>		
• Office Visits	No copay	\$10
• Visit to a Specialist	No copay	\$10
• Annual Physicals	No copay	No copay
• Mammograms	No copay	No copay
• Vision Exams and Frames	\$10 (1 exam / year) (\$75 allowance / 24 months)	\$10 (\$150 allowance / 24 months)
• Hearing Exams	No copay (1 exam / year)	\$10
• X-Ray and Laboratory	No copay	No copay
• Chiropractic Services	\$5 (12 visits / cal year)	Not covered
• Dental Coverage	Yes	Not covered
<b>Emergency Service</b>		
• Hospital Emergency Room <i>(waived if admitted)</i>	\$20 / visit	\$50 / visit
• Hospital Inpatient Services	No copay	\$200 / admission
• Ambulance	No copay	\$50 / trip
<b>Inpatient Hospital</b>		
• Inpatient Surgery	No copay	\$200 / admission
• Mental or Nervous Disorders	No copay	\$200 / admission
• Acute Alcoholism or Drug Dependence	No copay	\$200 / admission
<b>Outpatient Hospital</b>		
• Outpatient Surgery	No copay	\$10 / procedure
• Mental or Nervous Disorders	No copay	\$10 / individual; \$5 / group
• Acute Alcoholism or Drug Dependence	No copay	\$10 / individual; \$5 / group
<b>Prescription</b>		
• Generic	\$7 (30 days)	\$10 (100 days)
• Brand	\$7 (30 days)	\$25 (100 days)
• Mail Order Prescription Drugs	\$15 (90 days)	\$10 / \$25 (100 days)
• Limits in a Calendar Year	Unlimited	\$2,930

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

# Out-of-State Plans

## Non-Medicare and Medicare

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

PPO 80 / 60 Plans: For Medicare participants, see "Coordination of Benefits" on page 17 of this Guide.

Summary of Services	www.anthem.com/ca		
	Anthem Blue Cross Blue Card Network 80 / 60 Plan Non-Medicare		Anthem Blue Cross Fee-For-Service 80 Plan Medicare
	In-Network Benefits	Out-of-Network Benefits	Benefit
<b>Maximum Lifetime Benefit</b>	Unlimited		Unlimited
<b>Annual Deductible</b>			
• Member	\$200	\$400	\$200
• Family	\$400	\$800	\$400
<b>Annual Out-of-Pocket Maximum</b>	\$2,000	\$4,000	\$3000/Single or \$6000/Family for any providers.
	<b>PPO MEMBER COPAY</b>	<b>NON-PPO MEMBER COPAY</b>	<b>MEMBER COPAY</b>
• Preventive Services	No copay	40%	No copay
• Office Visits	\$20 / deductible waived	40%	20%
• Visit to a Specialist	\$20 / deductible waived	40%	20%
• Annual Physicals	No copay	Not covered	20%
• Mammograms	No copay	40%	No copay
• Vision Exams and Frames	Not covered	Not covered	Not covered
• X-Ray and Laboratory	20%	20%	20%
• Chiropractic Services	20%	40% (limit \$25 / visit)	20%
• Dental Coverage	Not covered	Not covered	Not covered
<b>Emergency Service</b>			
• Hospital Emergency Room (deductible waived if admitted)	20%/deductible waived if admitted	20%/deductible waived if admitted	20%
• Hospital Inpatient Services	20%	40%	20%
• Ambulance	20%	20%	20%

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

# Out-of-State Plans (continued)

## Non-Medicare and Medicare

Summary of Services	www.anthem.com/ca		
	Anthem Blue Cross Blue Card Network 80 / 60 Plan Non-Medicare		Anthem Blue Cross Fee-For-Service 80 Plan Medicare
	In-Network Benefits	Out-of-Network Benefits	Benefit
	PPO MEMBER COPAY	NON-PPO MEMBER COPAY	MEMBER COPAY
<b>Inpatient Hospital*</b>			
• Inpatient Surgery	20%	40%	20%
• Mental or Nervous Disorders	20%	40%	20%
• Acute Alcoholism or Drug Dependence	20%	40%	20%
<b>Outpatient Hospital</b>			
• Outpatient Surgery	No copay & deductible waived	40%	20%
• Mental or Nervous Disorders	20%	40%	20%
• Acute Alcoholism or Drug Dependence	20%	40%	20%
<b>Prescription</b>			
• Generic	\$10 (30-day supply)	\$20 + 50% up to \$250 per prescription	\$10 (30-day supply)
• Brand	\$20 (30-day supply)	\$20 + 50% up to \$250 per prescription	\$20 (30-day supply)
• Mail Order Prescription Drugs	\$20/40 (90-day supply)	20/40 + \$100 up to \$250 per prescription	\$20 / \$40 (90-day supply)
• Limits in a Calendar Year	None		None

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

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

# Coordination of Benefits

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## Anthem Blue Cross 80 / 60 Plan

As a retired employee or the spouse or domestic partner of a retired employee who is eligible for Medicare Part A due to the earned quarterly contributions to the Social Security system or through your spouse or domestic partner's contributions; your benefits under these PPO Plans will be subject to Coordination of Benefits.

### Coordination of Benefits with Medicare

Anthem Blue Cross will not provide benefits under these plans that duplicate any benefits to which you would be entitled under Medicare. This exclusion applies to all parts of Medicare in which you can enroll without paying additional premium. If you are required to pay additional premium for any part of Medicare, this exclusion will apply to that part of Medicare only if you are enrolled in that part.

If you are entitled to Medicare, your Medicare coverage will not affect the services covered under these plans except the following:

1. Medicare must provide benefits first to any services covered both by Medicare and under these plans.
2. For services you receive that are covered both by Medicare and under these plans, coverage under these plans will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.
3. For any given claim, the combination of benefits provided by Medicare and the benefits provided under these plans will not exceed covered expense for the covered services.

Anthem Blue Cross will apply any charges paid by Medicare for services covered under these plans toward your plan deductible, if any.



# Pharmacy Plan – IngenioRx

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## Save time and money on prescriptions with home delivery

Getting your prescription drugs doesn't have to be a drag. We help make it easier and more convenient for you to get the medicines you need.



### Home delivery: Skip the drugstore line

If you take prescription medicines on a regular basis, you can get up to a 90-day supply delivered to your home.<sup>1</sup> And depending on your plan, you may save on copays. That's because a 90-day supply of many drugs usually costs less than three 30-day refills.

Missing even one dose of a medicine that treats long-term conditions like high blood pressure or diabetes may lead to serious health problems and higher health care costs. That's why home delivery is a great way to make sure you get your prescription refills when you need them.

Standard shipping is free, and you can set up automatic renewals to get your next three-month supply sent to you before the refill date.

### How to get started with home delivery

Getting set up for home delivery is easy. Just call the **Pharmacy Member Services** phone number on the back of your health plan ID card. You can also mail in your order with our order form found on [anthem.com/ca](http://anthem.com/ca). Choose **Individual & Family**, then **Forms**.

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# Pharmacy Plan – IngenioRx (continued)

## Need help?

Call the home delivery pharmacy at 1-833-203-1739 or call the Pharmacy Member Services phone number on the back of your health plan ID card.

You may want to ask your doctor for a 30-day prescription, which you can get filled at your regular pharmacy, to make sure you have enough medicine to last until you get your first home delivery prescription.

### Here are a few more important things to know

- Using our mobile app, Sydney Health, or [anthem.com/ca](https://www.anthem.com/ca) to switch to home delivery is only available if your Anthem pharmacy plan benefits include mandatory home delivery, opt-out home delivery or Rx Maintenance 90. If you have optional home delivery, call the **Pharmacy Member Services** phone number on the back of your health plan ID card, or complete and mail the *Home Delivery Order Form* to transfer your prescriptions from your retail pharmacy to home-delivery.

- If your doctor prescribes a brand-name drug, your pharmacy plan may require the home delivery pharmacy to send a generic version instead.
- All prescriptions and refills, including those sent by your doctor, will be filled as soon as the home delivery pharmacy gets them. In most cases, your first order will arrive within two weeks. After that, orders will arrive within one week.
- If you need your medicine sooner, you can call the home delivery pharmacy and ask for overnight delivery. You'll be charged extra for the faster shipping.
- With some drugs, you may need to sign to accept delivery.<sup>2</sup>



<sup>1</sup> Supplies vary based on your pharmacy plan design.

<sup>2</sup> Drugs that are defined as controlled substances are highly regulated, which requires the home delivery pharmacy to follow special rules for filling these prescriptions.

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.

# Dental

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

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

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

## High Option PPO & Buy-Up PPO

The High Option and Buy-Up are standard PPO programs in which members have the freedom to choose any dentist. The program pays a percentage for covered services. Provider directories are available in Human Resources or you can access the information at the Guardian website [www.guardiananytime.com](http://www.guardiananytime.com) under the Preferred Network.

## MDC-G90 DMO

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

### Note

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

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

# Dental (continued)

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

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

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

# Vision

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

## You'll like what you see with VSP.

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

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

## Using Your VSP Benefit is Easy

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

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

## Choice in Eyewear

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

Visit [www.vsp.com](https://www.vsp.com) or call 800.877.7195 for more details on your vision coverage and exclusive savings and promotions for VSP members.



# Vision (continued)

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

## Vision Service Plan (VSP) Eligibility

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

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

Benefit	Description	Copay	Frequency
<b>WellVision Exam</b>	Focuses on your eyes and overall wellness	\$10 for exam and glasses	Every 12 months
<b>Prescription Glasses</b>			
<b>Frame</b>	<ul style="list-style-type: none"> <li>\$150 allowance for a wide selection of frames</li> <li>\$170 allowance for featured frame brands</li> <li>20% savings on the amount over your allowance</li> <li>\$80 Costco® frame allowance</li> </ul>	Combined with exam	Every 12 months
<b>Lenses</b>	<ul style="list-style-type: none"> <li>Single vision, lined bifocal, and lined trifocal lenses</li> <li>Polycarbonate lenses for dependent children</li> </ul>	Combined with exam	Every 12 months
<b>Lens Enhancements</b>	<ul style="list-style-type: none"> <li>Standard progressive lenses</li> <li>Premium progressive lenses</li> <li>Custom progressive lenses</li> </ul> Average savings of 20-25% on other lens enhancements	\$55 \$95 - \$105 \$150 - \$175	Every 12 months
<b>Contacts</b> (instead of glasses)	<ul style="list-style-type: none"> <li>\$130 allowance for contacts and contact lens exam (fitting and evaluation)</li> </ul>	\$0	Every 12 months
<b>Diabetic Eyecare Plus Program</b>	<ul style="list-style-type: none"> <li>Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.</li> </ul>	\$20	As needed
<b>Extra Savings</b>	<b>Glasses and Sunglasses</b> <ul style="list-style-type: none"> <li>Extra \$20 to spend on featured frame brands. Go to <a href="http://vsp.com/specialoffers">vsp.com/specialoffers</a> for details.</li> <li>20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.</li> </ul>		
	<b>Retinal Screening</b> <ul style="list-style-type: none"> <li>No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam</li> </ul>		
	<b>Laser Vision Correction</b> <ul style="list-style-type: none"> <li>Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities</li> </ul>		

## Your Coverage with Out-of-Network Providers

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

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

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

## THE ULTIMATE PROVIDER PLAYLIST

The right song can set the mood, and the right vision provider can set the tone for a great eye care experience. With VSP®, your employees have the freedom to choose a provider they can really groove with.



**MORE CHOICES.  
MORE FREEDOM.**

**VSP NETWORK PROVIDERS  
84K ACCESS POINTS**



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

### Independent Doctors

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

24-hour access to emergency care.

Eye Health Management Program®.

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



### Retail Chains

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



### Effortless Out-of-network Shopping

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



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

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

# Other Benefits

## Health and Wellness

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

### Tips for Using Your Benefits Wisely

#### Use Preventive Care Benefits

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

#### Visit an Urgent Care Facility Instead of the ER

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

#### Choose Generic Drugs

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

#### Use Anthem's Online Tools

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

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

# Health and Wellness (continued)

## Use Kaiser's Online Tools

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

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

## Patient Advocacy Tools

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

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



# Retired City Guidelines

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## Medical Guidelines and Provisions

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

## Dental and Vision Guidelines and Provisions

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

# Retired City Guidelines (continued)

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## Life Guidelines and Provisions

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



### **IMPORTANT**

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

# Retiree Billing Services

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

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

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

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

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

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

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

## IMPORTANT

You must notify the City of Glendale when terminating coverage.

City of Glendale  
Benefits Division  
613 E. Broadway, Room 100  
Glendale, CA 91206  
818.548.2160  
[benefits@glendaleca.gov](mailto:benefits@glendaleca.gov)

# Miscellaneous

## Health Care Reform Update

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

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

### Meeting the Individual Mandate

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

#### Government-Sponsored Programs

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

#### Health Insurance Marketplace or Individual Market

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

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

#### Other Health Coverage

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

#### No Coverage

You also have the option to not have any health insurance in 2020. However, if you choose to be uninsured in 2020 you will pay a tax penalty when you file your 2020 taxes (to determine your potential tax penalty, go to [www.HealthCare.gov](http://www.HealthCare.gov)).

# Legal Notices

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## Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

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

## Patient Protections

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

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

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

## Networks/Claims/Appeals

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

## Notice of Extended Coverage to Children Covered as Students

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

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

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

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

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

# Legal Notices (continued)

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

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

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

## COBRA Continuation Coverage

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

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

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

### WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation

coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

### WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. The employer must notify the Plan Administrator of the following Qualifying Events:

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

# Legal Notices (continued)

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

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

## NOTICE AND ELECTION PROCEDURES

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

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

## ELECTION AND ELECTION PERIOD

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

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

## HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

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

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

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

# Legal Notices (continued)

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## OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

## IF YOU HAVE QUESTIONS

For more information about the Marketplace, visit [www.healthcare.gov](http://www.healthcare.gov).

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

## KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

## EFFECTIVE DATE OF COVERAGE

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

## COST OF CONTINUATION COVERAGE

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

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

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

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

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

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

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

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

# Legal Notices (continued)

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## Special Enrollment Rights Notice

### CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

For information about Special Enrollment Rights, please contact:

City of Glendale  
Human Resources, Benefits Division  
818.548.2160

## Medicare Part D – Important Notice About Your Prescription Drug Coverage and Medicare

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

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

- **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- **City of Glendale has determined that the prescription drug coverage offered by Anthem Blue Cross and Kaiser Medical Plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

### WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

# Legal Notices (continued)

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

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

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

## WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with City of Glendale and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (i.e., a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Glendale changes. You also may request a copy of this notice at any time.

## FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

## FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 800.772.1213 (TTY 800.325.0778).

## REMEMBER

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

Date: March 23, 2020  
Name of Entity / Sender: City of Glendale  
Contact: Human Resources  
Address: 613 E. Broadway, Room 100  
Glendale, CA 91206  
Phone: 818.548.2160

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

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

# Legal Notices (continued)

## Health Insurance Marketplace Coverage Options and Your Health Coverage

### PART A: GENERAL INFORMATION

This notice provides you with information about City of Glendale in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855.653.3626 or at [www.KeenanDirect.com](http://www.KeenanDirect.com), or (for everyone) contact the Health Insurance Marketplace directly at [www.Healthcare.gov](http://www.Healthcare.gov).

#### WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through Covered California is anticipated to begin October 15, 2020 and end on the following January 31. Open Enrollment for most other states will begin on November 1 and close on December 15 of each year.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not “Affordable,” or does not provide “Minimum Value.” If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.78% (for 2020) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

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

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

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

### PART B: EXCHANGE APPLICATION INFORMATION

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855.653.3626 or at [www.KeenanDirect.com](http://www.KeenanDirect.com).

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

# Legal Notices (continued)

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## 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](http://www.healthcare.gov).

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 877.KIDS.NOW or [www.insurekidsnow.gov](http://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](http://www.askebsa.dol.gov) or call 866.444.EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility.

**ALABAMA – Medicaid**  
Website: <http://myalhipp.com/>  
Phone: 855.692.5447

**ALASKA – Medicaid**  
The AK Health Insurance Premium Payment Program  
Website: <http://myakhipp.com/>  
Phone: 866.251.4861  
Email: [CustomerService@MyAKHIPP.com](mailto:CustomerService@MyAKHIPP.com)  
Medicaid Eligibility:  
<http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

**ARKANSAS – Medicaid**  
Website: <http://myarhipp.com/>  
Phone: 855.MyARHIPP (855.692.7447)

**CALIFORNIA – Medicaid**  
Website:  
[www.dhcs.ca.gov/services/Pages/TPLRD\\_CAU\\_cont.aspx](http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx)  
Phone: 800.541.5555

**COLORADO – Health First Colorado**  
Colorado's Medicaid Program & Child Health Plan Plus (CHIP+) Healthy First Colorado Website:  
<https://www.healthfirstcolorado.com/>  
Health First Colorado Member Contact Center: 800.221.3943  
TTY: Colorado relay 711  
CHP+: <https://www.colorado.gov/pacific/hcpf/child-health-plan-plus>  
CHP+ Customer Service: 800.359.1991  
TTY: Colorado relay 711

**FLORIDA – Medicaid**  
Website: <http://flmedicaidplrecovery.com/hipp/>  
Phone: 877.357.3268

**GEORGIA – Medicaid**  
Website: <http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp/>  
Phone: 678.564.1162, ext. 2131

**INDIANA – Medicaid**  
Healthy Indiana Plan for low-income adults 19-64  
Website: <http://www.in.gov/fssa/hip/>  
Phone: 877.438.4479  
All other Medicaid  
Website: <http://www.indianamedicaid.com>  
Phone: 800.403.0864

**IOWA – Medicaid and CHIP (Hawki)**  
Medicaid Website: <https://dhs.iowa.gov/ime/members>  
Medicaid Phone: 800.338.8366  
Hawki Website: <http://dhs.iowa.gov/Hawki>  
Phone: 800.257.8563

**KANSAS – Medicaid**  
Website: <http://www.kdheks.gov/hcf/default.htm>  
Phone: 800.792.4884

**KENTUCKY – Medicaid**  
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:  
<https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx>  
Phone: 855.459.6328  
Email: [KIHIPPPROGRAM@ky.gov](mailto:KIHIPPPROGRAM@ky.gov)  
KCHIP Website: <https://kidshealth.ky.gov/Pages/index.aspx>  
Phone: 877.524.4718  
Kentucky Medicaid Website: <https://chfs.ky.gov>

**LOUISIANA – Medicaid**  
Website: [www.medicaid.la.gov](http://www.medicaid.la.gov) or [www.ldh.la.gov/lahipp](http://www.ldh.la.gov/lahipp)  
Phone: 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)

**MAINE – Medicaid**  
Website: <http://www.maine.gov/dhhs/ofi/public-assistance/index.html>  
Phone: 800.442.6003  
TTY: Maine relay 711

# Legal Notices (continued)

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## **MASSACHUSETTS – Medicaid and CHIP**

Website: <http://www.mass.gov/eohhs/gov/departments/masshealth/>  
Phone: 800.862.4840

## **MINNESOTA – Medicaid**

Website: <https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp> [Under Eligibility tab, see “what if I have other health insurance?”]  
Phone: 800.657.3739

## **MISSOURI – Medicaid**

Website: <https://www.dss.mo.gov/mhd/participants/pages/hipp.htm>  
Phone: 573.751.2005

## **MONTANA – Medicaid**

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>  
Phone: 800.694.3084

## **NEBRASKA – Medicaid**

Website: <http://www.ACCESSNebraska.ne.gov>  
Phone: 855.632.7633  
Lincoln: 402.473.7000  
Omaha: 402.595.1178

## **NEVADA – Medicaid**

Medicaid Website: <https://dhcfp.nv.gov/>  
Medicaid Phone: 800.992.0900

## **NEW HAMPSHIRE – Medicaid**

Website: <http://www.dhhs.nh.gov/oii/documents/hippapp.pdf>  
Phone: 603.271.5218  
Toll-Free for the HIPP program: 800.852.3345, ext. 5218

## **NEW JERSEY – Medicaid and CHIP**

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>  
Medicaid Phone: 609.631.2392  
CHIP Website: <http://www.njfamilycare.org/index.html>  
CHIP Phone: 800.701.0710

## **NEW YORK – Medicaid**

Website: [https://www.health.ny.gov/health\\_care/medicaid/](https://www.health.ny.gov/health_care/medicaid/)  
Phone: 800.541.2831

## **NORTH CAROLINA – Medicaid**

Website: <https://medicaid.ncdhhs.gov/>  
Phone: 919.855.4100

## **NORTH DAKOTA – Medicaid**

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>  
Phone: 844.854.4825

## **OKLAHOMA – Medicaid and CHIP**

Website: <http://www.insureoklahoma.org>  
Phone: 888.365.3742

## **OREGON – Medicaid**

Websites: <http://healthcare.oregon.gov/Pages/index.aspx>  
<http://www.oregonhealthcare.gov/index-es.html>  
Phone: 800.699.9075

## **PENNSYLVANIA – Medicaid**

Website: <https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx>  
Phone: 800.692.7462

## **RHODE ISLAND – Medicaid and CHIP**

Website: <http://www.eohhs.ri.gov/>  
Phone: 855.697.4347, or 401.462.0311 (Direct Rlte Share Line)

## **SOUTH CAROLINA – Medicaid**

Website: <https://www.scdhhs.gov>  
Phone: 888.549.0820

## **SOUTH DAKOTA – Medicaid**

Website: <http://dss.sd.gov>  
Phone: 888.828.0059

## **TEXAS – Medicaid**

Website: <http://gethipptexas.com/>  
Phone: 800.440.0493

## **UTAH – Medicaid and CHIP**

Medicaid Website: <https://medicaid.utah.gov/>  
CHIP Website: <http://health.utah.gov/chip>  
Phone: 877.543.7669

## **VERMONT – Medicaid**

Website: <http://www.greenmountaincare.org/>  
Phone: 800.250.8427

## **VIRGINIA – Medicaid and CHIP**

Website: <https://www.coverva.org/hipp/>  
Medicaid Phone: 800.432.5924  
CHIP Phone: 855.242.8282

## **WASHINGTON – Medicaid**

Website: <https://www.hca.wa.gov/>  
Phone: 800.562.3022

## **WEST VIRGINIA – Medicaid**

Website: <http://mywvhipp.com/>  
Toll-free phone: 855.MyWVHIPP (855.699.8447)

## **WISCONSIN – Medicaid and CHIP**

Website: <https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf>  
Phone: 800.362.3002

## **WYOMING – Medicaid**

Website: <https://wyequalitycare.acs-inc.com/>  
Phone: 307.777.7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

## **U.S. Department of Labor**

Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)  
866.444.EBSA (3272)

## **U.S. Department of Health and Human Services**

Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
877.267.2323, Menu Option 4, Ext. 61565

# Contact Information

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

For Questions About ...	Phone	E-mail / Website
<b>Benefits or Enrolling</b>		
• Deisi Contreras, Sr. Benefits Specialist	818.548.2160	<a href="mailto:benefits@glendaleca.gov">benefits@glendaleca.gov</a>
• Adrine Gdakian, Benefits Assistant	818.548.2160	<a href="mailto:benefits@glendaleca.gov">benefits@glendaleca.gov</a>
<b>City's Retirement Process</b>		
• Teri Taylan, Benefits Manager	818.548.2110	<a href="mailto:ttaylan@glendaleca.gov">ttaylan@glendaleca.gov</a>
<b>City's Retirement Billing</b>		
• PayFlex	800.359.3921	<a href="http://www.payflex.com">www.payflex.com</a>
<b>City's Deferred Compensation Plans and RHSP</b>		
• Appointments	<a href="https://icmarc.secure.force.com/events?SiteId=a0lj0000003QO3LAAW">https://icmarc.secure.force.com/events?SiteId=a0lj0000003QO3LAAW</a>	
<b>Medical Plans</b>		
• Anthem Blue Cross		
– PPO & HMO	800.288.2539	<a href="http://www.anthem.com/ca">www.anthem.com/ca</a>
– Senior Secure	800.225.2273	
• Anthem Rx (Mail Order)	866.274.6825	<a href="http://www.anthem.com/ca">www.anthem.com/ca</a>
• Kaiser Permanente	800.464.4000	<a href="http://www.kp.org">www.kp.org</a>
• FuturisCare Retiree Services	888.616.7130	<a href="http://www.healthcompare.com/futuriscare">www.healthcompare.com/futuriscare</a>
• Keenan Direct	855.359.7354	<a href="http://www.keenandirect.com">www.keenandirect.com</a>
<b>Dental Plans</b>		
• Guardian		
• PPO	800.541.7846	<a href="http://www.guardiananytime.com">www.guardiananytime.com</a>
• DMO	800.459.9401	<a href="http://www.guardiananytime.com">www.guardiananytime.com</a>
<b>Vision Plan</b>		
• Vision Service Plan (VSP)	800.877.7195	<a href="http://www.vsp.com">www.vsp.com</a>
<b>Pension Plans</b>		
• CalPERS 655 N. Central Avenue, Suite 1400 Glendale, CA 91203	888.225.7377	<a href="http://www.calpers.ca.gov">www.calpers.ca.gov</a>
• PARS-ARS	800.540.6369	<a href="http://www.pars.org">www.pars.org</a>
<b>Social Security and Medicare</b>		
• Social Security	800.772.1213	<a href="http://www.ssa.gov">www.ssa.gov</a>

*Keenan*