

EMPLOYEE

BENEFITS GUIDE



20
21



General Information

1. Human Resources Contact Information
2. Carrier Contact Information
3. Introduction
4. Eligibility and Enrollment

Core Benefits

11. Considering Your Health Plan Choices
12. Understanding How CalPERS Health Plans Work
13. Rates
15. Medical - 2021 CalPERS EPO & HMO Basic Plans
18. Medical - 2021 CalPERS PPO Basic Plans
21. Obtaining Health Care Quality Information
22. Dental
25. Vision

Other Benefits

26. Basic Life & AD&D
28. 457 Deferred Compensation Plan
28. CalPERS Retirement System
28. Public Agency Retirement System (PARS)
29. American Fidelity
 29. *Flexible Spending Accounts*
 33. *Short-Term Disability Income Insurance*
 34. *Accident Only Insurance*
 35. *Cancer Insurance*
 36. *Group Critical Illness Insurance*
38. Employee Assistance Program
39. The Hartford Life Insurance Assistance
45. The Hartford Travel and ID Theft Protection
47. Long Term Disability
48. Disability & Leaves of Absence

Miscellaneous

49. Important Notices

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 53 for more details.

The information in this brochure is a general outline of the benefits offered under The City of El Monte's benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

Human Resources Contact Information

Employee Benefits Programs	Contact
Benefits Coordination (Medical, Dental & Vision Insurance)	Bianca King - Sr. Management Analyst
COBRA Continuation	Bianca King - Sr. Management Analyst
Flexible Spending Accounts	Bianca King - Sr. Management Analyst
Voluntary Plan Administration	Bianca King - Sr. Management Analyst
Deferred Compensation	Bianca King - Sr. Management Analyst
Employee Assistance Program	Bianca King - Sr. Management Analyst
Fair Employment Housing Act (FEHA) Americans for Disabilities Act (ADA)	John Ngyuen - HR/RM Director
Family Medical Leave Act (FMLA)	Annabel Martinez - HR/RM Specialist
Leave Administration	Annabel Martinez - HR/RM Specialist
Workers' Compensation	John Nguyen - HR/RM Director
Life Insurance & Disability Insurance	Bianca King - Sr. Management Analyst

Contact	Email	Phone
Human Resources Team		
<ul style="list-style-type: none"> • John Nguyen HR/RM Director 	jnguyen@elmonteca.gov	626.580.2017
<ul style="list-style-type: none"> • Kristen Enomoto Sr. Management Analyst 	kenomoto@elmonteca.gov	626.580.2044
<ul style="list-style-type: none"> • Bianca King Sr. Management Analyst 	bking@elmonteca.gov	626.580.2052
<ul style="list-style-type: none"> • Annabel Martinez Human Resources & Risk Management Specialist 	abmartinez@elmonteca.gov	626.580.2049



Carrier Contact Information

Below is a listing of the telephone numbers you can call with questions about the plans available to you. You can also use the web site (if available) to access information from providers for the various plans.

Benefit Information: www.benefitbridge.com/cityofelmonte

Plan	Phone Number	Web Site
Medical <i>(To request a free paper copy of the SBC and glossary, please contact each health plan directly.)</i>		
• Anthem Blue Cross	877.737.7776	www.anthem.com/ca/calpers
• Blue Shield	800.334.5847	www.blueshieldca.com/calpers
• Kaiser Permanente	800.464.4000	www.kp.org/calpers
• UnitedHealthcare Alliance	Active: 877.359.3714 Retirees: 888.867.5581	www.uhc.com/calpers
• Peace Officers Research Association of California (PORAC)	800.288.6928	www.ibtoforac.org
• PERS Select, PERS Choice & PERSCare	877.737.7776	www.anthem.com/ca/calpers
• Health Net	888.926.4921	www.healthnet.com/calpers
Dental		
• MetLife	800.942.0854	www.metlife.com
Vision		
• EyeMed	866.939.3633	www.eyemed.com
• United Health Care	866.414.1959	www.uhc.com
Employee Assistance Program (EAP)		
• MHN	800.227.1060	mhn.advantageengagement.com Company Code: elmonte
Basic Life / AD&D, Optional Life		
• The Hartford	800.523.2233	www.thehartford.com
Long Term Disability (LTD)		
• The Standard	800.368.1135	www.thestandard.com
Flexible Spending Accounts (FSA), Dependent Care and Other Benefits		
• American Fidelity	800.662.1113	www.americanfidelity.com
• Aflac	800.992.3522	www.aflac.com
• Allstate	877.810.2920	www.allstate.com
Deferred Compensation		
• Nationwide Guadalupe Ayala	877.677.3678	ayalag2@nationwide.com

Introduction

At the City of El Monte we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each and every employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all of our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

In order to activate your benefits, complete and submit the following:

- CalPERS Beneficiary Designation Form
- CalPERS Reciprocal
- Register on the BenefitBridge Website (www.benefitbridge.com/cityofelmonte)
- **If covering dependent(s):** deliver or upload required documents to HR. (documents listed on page 6).

Optional Benefit Forms

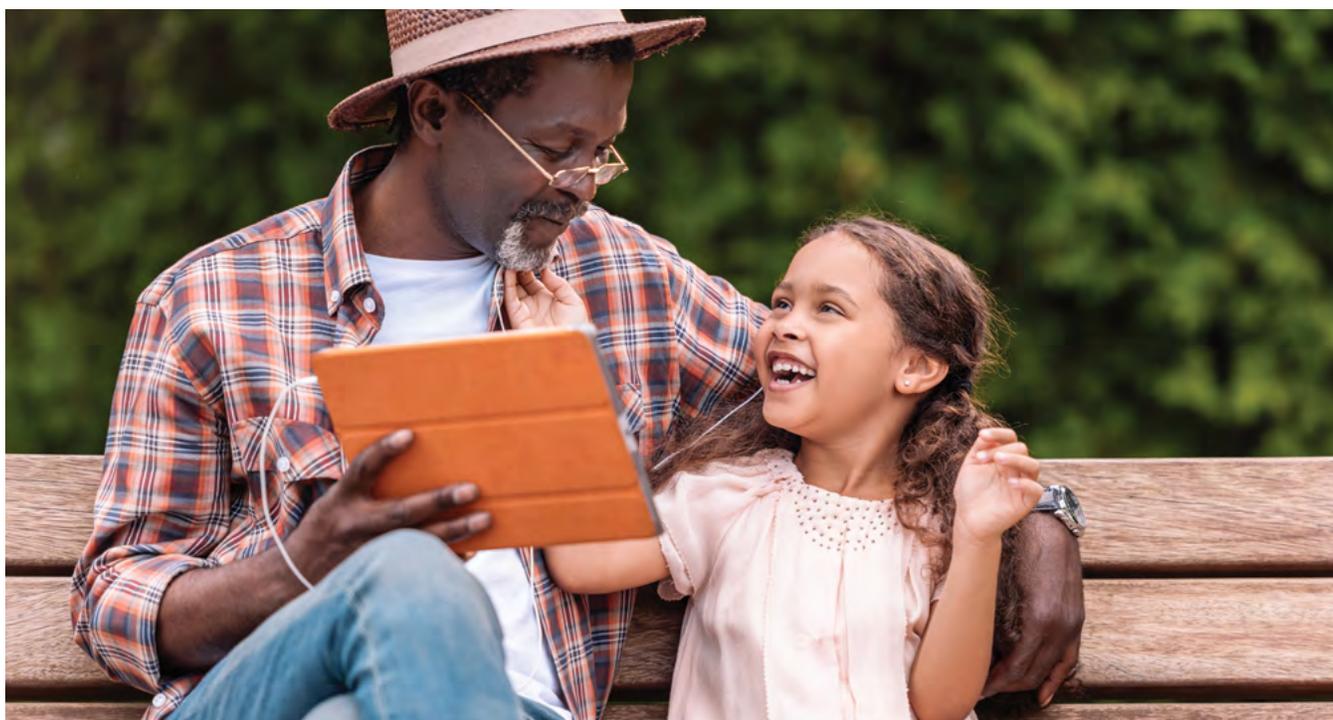
- Flexible Spending Plan Enrollment form

Enrollment and Benefit Choices

The City recognizes that your benefits are an important part of the reason you choose to work here. The City provides high quality benefits at a reasonable cost to you. You can choose between different medical plans to meet your individual and family needs. Since you have some choices to make, it is important to understand the various programs. That is why this Handbook is being provided for you. Benefits provided by the City for eligible employees include a choice of CalPERS medical plans, dental plans, vision plans, group life insurance coverage, group disability and optional voluntary benefits.

You have 30 days from the date of your initial appointment to enroll, or decline coverage for yourself and eligible family members. Benefits will begin on the 1st of the month after you submit your paperwork and appropriate documentation to the Human Resources Department. If you do not enroll during the initial 30 days, you will be subject to a waiting period until the following open enrollment period.

Any questions you may have regarding the enclosed information can be referred to the corresponding representative listed in the contact information found at the beginning of this guide.



Eligibility and Enrollment

Who is Eligible for Benefits?

Employees

All regular City of El Monte employees working full time may be eligible for benefits. If you are enrolling as a new employee most benefits are effective the 1st of the month following your date of hire. You may also choose to enroll your eligible dependents in many of our benefits. Spouse (includes same sex domestic partner) and eligible dependent children to age 26 are covered for most plans. Contact the Human Resources Department for specific plan details.

Family Members

The terms "family member" and "dependent" are used interchangeably. Eligible family members include:

- Spouse
- Registered domestic partner
- Children (natural, adopted, domestic partner's, or step) up to age 26
- Children, up to age 26, if the employee or annuitant has assumed a parent-child relationship and is considered the primary care parent
- Certified disabled dependent children age 26 and older

Who Is Not Eligible for the CalPERS Health Program?

Ineligible Employees

- Those whose job classification is "Limited-Term/ Intermittent/part-time" (seasonal or temporary)
- Those whose appointment lasts less than six months

Ineligible Family Members

- Former spouses/former registered domestic partners
- Children age 26 and older
- Disabled children over age 26 who were never enrolled or who were deleted from coverage
- Children of a former spouse/former registered domestic partner
- Grandparents
- Parents

Do Not Enroll Ineligible Family Members

It is against the law to enroll ineligible family members. If you do so, CalPERS will retroactively cancel the enrollment and you may have to pay all costs incurred by the ineligible person from the date the coverage began.

Where to Get Help With Your Health Benefits Enrollment

All benefit changes must be done on the BenefitBridge website.

Once you retire, CalPERS becomes your Health Benefits Officer. As a retiree, you may make changes to your health plan in any of the following ways:

- **Online through my|CalPERS at:**
my.calpers.ca.gov during Open Enrollment
- **By writing to us at:**
P.O. Box 942715
Sacramento, CA 94229-2715
- **By calling us toll free at:**
888.CalPERS (or 888.225.7377).

For general information about health benefits, go to the CalPERS website at www.calpers.ca.gov. The chart on page 6 indicates the forms and supporting documentation needed for most changes.

Spouse

You may add your spouse to your health plan within 30 days of your marriage. You are required to provide a copy of the marriage certificate and the spouse's Social Security Number and Medicare card (if applicable). Your spouse's coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

Eligibility and Enrollment (continued)

Registered Domestic Partner

You may add your registered domestic partner to your health plan within 30 days of registration of the domestic partnership. The coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

To add a domestic partner to your health plan, you must register your domestic partnership through the California Secretary of State's Office or equivalent office from another state. Upon registration, that office will provide you with a Declaration of Domestic Partnership.

CalPERS requires that you submit a copy of the approved Declaration of Domestic Partnership, the domestic partner's Social Security number, and a copy of their Medicare card (if applicable).

Same sex domestic partnerships between persons who are both at least age 18 and certain opposite sex domestic partnerships (one partner must be 62 years of age or older and the other partner at least 18 years of age) are eligible to register with the Secretary of State. For more information about domestic partnership registration, visit the Secretary of State's website at www.sos.ca.gov.

Children

Natural-born, adopted, domestic partners, and stepchildren who are under age 26 may be added to your health plan, as outlined below:

- Newborn children should be added within 30 days of birth. Coverage is effective from the date of birth.
- Newly adopted children should be added within 30 days of physical custody. Coverage is effective from the date physical custody is obtained.
- Stepchildren or a domestic partner's children under age 26 can be added within 30 days after the date of your marriage or registration of your domestic partnership. The coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

Disabled Children Over Age 26

A child age 26 and over who is incapable of self-support because of a mental or physical condition may be eligible for enrollment. The disability must have existed prior to reaching age 26 and continuously since age 26, as certified by a licensed physician. You are required to complete and submit the Member Questionnaire for the CalPERS Disabled Dependent Benefit form, and the physician must complete and submit a Medical Report for the CalPERS Disabled Dependent Benefit form for CalPERS approval. The initial certification of the Disabled Dependent must occur during one of the following two eligibility periods (whichever applies):

- Within 30 days before and ending 30 days after the child's 26th birthday (member and dependent currently enrolled), **or**
- Within 30 days of a newly eligible employee's initial enrollment in the CalPERS Health Program

Upon certification of eligibility, the dependent's coverage must be continuous and without lapse. You will be required to submit an updated questionnaire and medical report for re-certification periodically, upon request.

Note: If the disabled child has a Social Security approved disability, you must provide CalPERS with a copy of his or her Medicare card.

Dependents in a Parent-Child Relationship

A child other than an adopted, step, or recognized natural child up to age 26 may be added to your health plan if you have assumed parental status, or assumed the parental duties as certified at the time of enrollment of the child, and annually thereafter up to the age of 26.

You have 30 days from the date you obtained custody of the child to enroll him or her on your health plan. Prior to enrollment of a dependent who is in a parent-child relationship, you must complete and submit an Affidavit of Parent-Child Relationship. You will be required to provide supporting documentation as indicated on the Affidavit of Parent-Child Relationship. Coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

Eligibility and Enrollment (continued)

For dependents under the age of 19, the annual re-certification will require a copy of the first page of your income tax return from the previous year listing the child as a tax dependent. In lieu of a tax return, for a time not to exceed one tax filing year, you may submit other documents that substantiate the child's financial dependence.

For dependents from age 19 up to age 26, the annual re-certification requires: A copy of the first page of your income tax return from the previous tax year listing the child as a tax dependent; or Documents that substantiate that the child is financially dependent, provided that the child: either lives with you for more than 50 percent of the time, or is a full-time student; and, is dependent upon you for more than 50 percent of his or her support.

Split Enrollments

When two active or retired members are married to each other or in a domestic partnership, each member can enroll separately. However, when these individuals enroll in a CalPERS health plan in their own right, one parent must carry all dependents on one health plan. Parents cannot split enrollment of dependents. CalPERS will retroactively cancel split enrollments. You may be responsible for all costs incurred from the date the split enrollment began.

Enrolling in Two CalPERS Health Plans

Dual CalPERS coverage occurs when you are enrolled in a CalPERS health plan as both a member and a dependent or as a dependent on two enrollments. This duplication of coverage is against the law. When dual CalPERS coverage is discovered, the enrollment that caused the dual coverage will be retroactively canceled. You may be responsible for all costs incurred from the date the dual coverage began.

Members may enroll in both a CalPERS health plan and a health plan provided through another employer. For example, a spouse may enroll in a CalPERS plan and in the plan from his or her private employer. In this case, the two plans may coordinate benefits.

Enrollment Type	Copies of Supporting Documentation*
Active employee – New enrollment	<ul style="list-style-type: none"> ID, Social Security Card
Adding a registered domestic partner	<ul style="list-style-type: none"> Declaration of Domestic Partnership from the California Secretary of State's Office Medicare card (if applicable)
Adding a spouse	<ul style="list-style-type: none"> Marriage Certificate,* Social Security Card and Medicare card (if applicable) ID
Adding a dependent who is in a parent-child relationship (PCR)	<ul style="list-style-type: none"> Required supporting documentation as indicated on the Affidavit of Parent-Child Relationship.
Adding/deleting a dependent child	<ul style="list-style-type: none"> Medicare card (if applicable)* Reason for add/delete Birth Certificate, social security card(s)
Changing plans due to address change	<ul style="list-style-type: none"> Include both old and new addresses
Deleting a registered domestic partner due to termination of partnership	<ul style="list-style-type: none"> Termination of Domestic Partnership submitted to the California Secretary of State's Office
Deleting a spouse due to divorce	<ul style="list-style-type: none"> Divorce Decree
Disabled child over age 26 – certification	<ul style="list-style-type: none"> Member Questionnaire for the CalPERS Disabled Dependent Benefit form Medical Report for the CalPERS Disabled Dependent Benefit form
Enrolling self or dependents due to loss of other health coverage	<ul style="list-style-type: none"> Certificate of Creditable Coverage, or other proof of loss of coverage Birth Certificate and Social Security Card(s) (Child) Marriage Certificate, ID and Social Security Card (Spouse) Declaration of Domestic Partnership (domestic partner)

* **Note:** Do not submit original documents as your documentation will not be returned. All changes must be made via the Benefit Bridge Website: www.benefitbridge.com/cityofelmonte

Eligibility and Enrollment (continued)

City of El Monte Online Benefits Enrollment is easy with BenefitBridge!



Need Help?

For all questions related to your benefits, please contact your employer's benefits administrator. For BenefitBridge technical assistance **only**, please contact BenefitBridge Customer Care at 800.814.1862; Mon – Fri, 8:00 a.m. – 5:00 p.m., PST or email benefitbridge@keenan.com.

Here's what you can do on BenefitBridge:

- View Current Plan Year Benefits
- Compare Plan Options
- Enroll in Benefits
- Resource Center: Health Insurance Basics, Medicare, Glossary, Media Resources
- Add or Remove Dependents/Beneficiaries
- Message Center
- Update My Account Info
- Available 24/7 via the Internet

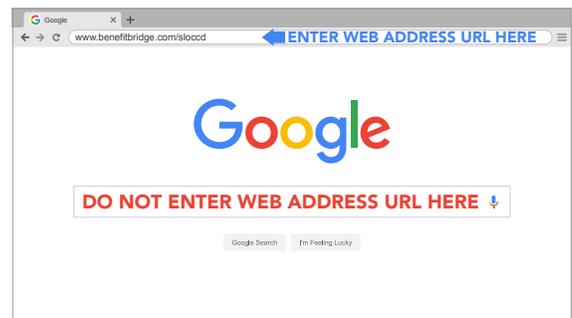
Registration and Login

Already have login credentials?

1. Login to BenefitBridge at www.benefitbridge.com/cityofelmonte
2. Forgot your Username or Password? Click on **"Forgot Username/Password?"**
3. Please add or update your email address to receive an email confirmation of your enrollment approval.

Need to create login credentials?

4. In the address bar, type www.benefitbridge.com/cityofelmonte
(Not in the Google, Yahoo, Bing, etc. search engine field)
5. Click the **Enter** key, then follow the instructions below to register:
 - **STEP 1:**
Select **"Register"** to **Create an Account**
 - **STEP 2:**
Create a **Username** and **Password**
 - **STEP 3:**
Select **"Continue"** to access **BenefitBridge**



Enrolling in Benefits

Access your enrollment via the **"Make Changes to My Benefits"** button

For BenefitBridge technical assistance only, please contact BenefitBridge Customer Care at

800.814.1862

Monday – Friday, 8:00 AM - 5:00 PM, PST or email benefitbridge@keenan.com.

Eligibility and Enrollment (continued)

Life Changes and Their Impact on Benefits

Outside of the annual open enrollment period, an employee may change an enrollment election (i.e., add or delete dependents, change level of coverage) only if there has been a “major life event.”

Name or Address Changes

If you move or change your name or contact information for any reason, including Marriage or Divorce, you must change your name through your employer. That way you will receive all your benefit information in a timely manner.

Health Benefits Coverage

Since you must choose a CalPERS health plan that provides coverage in your work or home ZIP code, a change in your address could mean you have to change plans. You can use our Health Plan Search by ZIP Code on line service to see what plans are available in your new ZIP code.

Marriage

Retirement Impact – Your marriage revokes a designation you may have on file. In most instances, you must be married for at least one year prior to your retirement date for survivor benefits to be payable to your spouse. Review your beneficiary designation. If you need to make changes, log in to your my CalPERS account to make changes online or complete the appropriate designation form.

You should also consider establishing a **CalPERS Special Power of Attorney**, or reviewing your current one. Read the **CalPERS Special Power of Attorney (PUB 30)** (PDF) publication for more information.

Health Benefits Coverage – Contact Human Resources as soon as possible to add your new spouse and any stepchildren to your health coverage. Your employer will need a copy of your marriage certificate and new spouse’s Social Security number, as well as birth certificates and social security cards for step children.

Divorce

Retirement Impact – Your CalPERS benefits are considered community property under California law. To see how this may impact your benefits, review Community Property (PUB38AI PDF) or CalPERS at 888.225.7377. Your dissolution of marriage revokes a designation you may currently have on file with CalPERS. Review your beneficiary designation. If you need to make changes, log in to your my CalPERS account to make changes online or complete the appropriate designation form.

You may also want to review your current Power of Attorney, or consider designating one. Review the **CalPERS Special Power of Attorney (PUB 30)** (PDF) for more information.

Health Benefits Coverage – You must remove your ex-spouse from your health plan as required by California Public Employees’ Retirement Law. Your ex-spouse’s entitlement to coverage ends at midnight on the last day of the month that your marriage dissolution is final. Contact Human Resources to modify your health plan. Your employer will need a copy of your divorce decree.

Registered Domestic Partnership

To find out more about registering a domestic partner, visit the Secretary of State website.

Retirement Impact – Your domestic partnership revokes a designation you may have on file . Review your beneficiary designation. If you need to make changes, log in to your my CalPERS account to make changes online, or complete the appropriate designation form depending on if you’re still working or retired:

Health Benefits Coverage – Contact Human Resources as soon as possible to add your domestic partner and their children to your health coverage. Your employer will need a copy of your certificate of domestic partnership registration.

Eligibility and Enrollment (continued)

Terminate Domestic Partnership

To find out more about terminating a domestic partnership, visit the Secretary of State website.

Retirement Impact – Your CalPERS benefits are considered community property under California law. To see how this may impact your benefits, review Community Property (PUB 38A) (PDF). CalPERS will need a copy of your property settlement agreement.

The termination of your domestic partnership revokes a designation you may have on file. Review your beneficiary designation. If you need to make changes, log in to your myCalPERS account to make changes online or complete the appropriate designation form.

You may also want to review your current Power of Attorney, or consider designating one. Review the CalPERS Special Power of Attorney (PUB 30) (PDF) for more information.

Health Benefits Coverage – You must remove your former domestic partner from your health plan. Their entitlement to coverage ends at midnight on the last day of the month that your partnership termination is final. Contact Human Resources to have your former domestic partner removed from your health plan. Your employer will need a copy of your termination document.

Birth or Adoption

See what details should be taken care of if you have or adopt a child.

Retirement Impact – The birth or adoption of a child revokes a beneficiary designation you may currently have on file. Review your beneficiary designation. If you need to make changes, log in to your my CalPERS account to make changes on line, or complete the appropriate designation forms.

Health Benefits Coverage – Contact Human Resources as soon as possible to add your new child to your health coverage. Your employer will need a copy of the birth certificate or adoption papers, and a copy of your new child's Social Security number.

Additional Documents to Consider Updating/Reviewing

- 457 Deferred Comp ICMA/Nationwide/Pentegra Beneficiary
- Checks Recipient Designation
- Emergency Contact
- Lincoln Life Insurance (Add, Delete, and/or change Beneficiary)

Additional Enrollment Opportunities

New employees and their dependents may initially enroll in a CalPERS health plan as indicated in the previous sections. Additional enrollment options and guidelines are described below.

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) to improve portability and continuity of health insurance coverage in the group insurance markets. HIPAA requirements for CalPERS took effect in 1998. HIPAA offers two provisions for employees and family members to enroll in CalPERS health plans outside of the initial enrollment period and the Open Enrollment period.



Eligibility and Enrollment (continued)

Special Enrollment

Special Enrollment refers to certain types of enrollment after your initial enrollment, but outside of the Open Enrollment period. You may need Special Enrollment under the following circumstances:

You lose other health coverage: If you initially declined (or canceled) enrollment for yourself or your dependents (including your spouse) because you had other private or CalPERS health coverage at that time, you may be able to enroll in a CalPERS health plan if the other coverage involuntarily ends. To qualify, you will need to request enrollment within 30 days after the other coverage ends and provide proof that the other coverage has ended.

You have new family members: When you enroll, you must enroll yourself or yourself and all eligible family members. If you later have a new dependent as a result of marriage, domestic partnership registration, birth, change of custody, adoption, or placement for adoption, you may enroll yourself and all eligible dependents within 30 days of that event.

The effective date for a Special Enrollment is the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

Late Enrollment

If you decline or cancel enrollment for yourself or your dependents and the Special Enrollment exceptions do not apply, your right to enroll (or add dependents) will be limited. You will have to wait until the next CalPERS Open Enrollment period. The earliest effective date of enrollment will be January 1st following the Open Enrollment period.



Considering Your Health Plan Choices

The City of El Monte offers several different medical plan options; Health Maintenance Organizations (HMO) or Preferred Provider Organizations (PPO) for all full-time employees and their eligible dependents through CalPERS.

Selecting a health plan for yourself and your family is one of the most important decisions you will make. This decision involves balancing the cost of each plan, along with other features, such as access to doctors and hospitals, pharmacy services, and special programs for managing specific medical conditions. Choosing the right plan ensures that you receive the health benefits and services that matter to you.

If you are a new Cal PERS member or you are considering changing your health plan during Open Enrollment, you will need to make two related decisions:

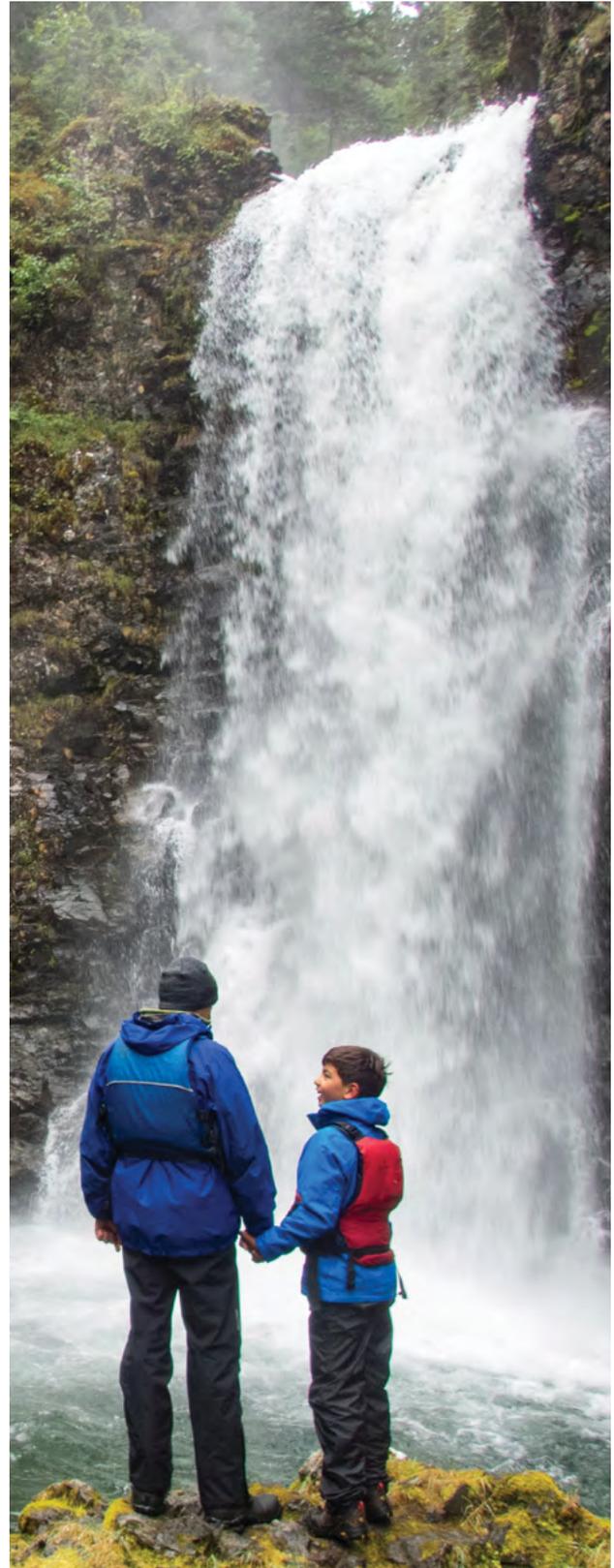
- Which health plan is best for you and your family?
- Which doctors and hospitals do you want to provide your care?

The combination of health plan and providers that is right for you depends on a variety of factors, such as whether you prefer a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO); your premium and out-of-pocket costs; and whether you want to have access to specific doctors and hospitals.

We realize that comparing health plan benefits, features, and costs can be complicated. This section provides information that can simplify your decision making process. As you begin that process, the following are some questions you should ask:

- **Do you prefer to receive your health care from an HMO or PPO?** Your preference will impact the plans available to you, your access to health care providers, and how much you pay for certain services. See the chart on the next page for a summary of the differences among plan types¹.
- **What are the costs (premiums, co-payments, deductibles, and coinsurance)?**
- **Does the plan provide access to the doctors and hospitals you want?** Contact health plans directly for this information. See the "Health Plan Directory"

1. Note that in a few counties where access to HMOs is limited, a third option. Exclusive Provider Organization (EPO). is available. An EPO provides benefits similar to an HMO with some PPO features.



Understanding How CalPERS Health Plans Work

The following chart will help you understand some important differences among health plan types.

Features	HMO	PPO
Accessing health care providers	<ul style="list-style-type: none"> Contracts with providers (<i>doctors, medical groups, hospitals, labs, pharmacies, etc.</i>) to provide you services at a fixed price 	<ul style="list-style-type: none"> Gives you access to a network of health care providers (<i>doctors, hospitals, labs, pharmacies, etc.</i>) known as preferred providers
Selecting a primary care physician (PCP)	<ul style="list-style-type: none"> Most HMOs require you to select a PCP who will work with you to manage your health care needs¹ 	<ul style="list-style-type: none"> Does not require you to select a PCP
Seeing a specialist	<ul style="list-style-type: none"> Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests 	<ul style="list-style-type: none"> Allows you access to many types of services without receiving a referral or advance approval
Obtaining care	<ul style="list-style-type: none"> Generally requires you to obtain care from providers who are a part of the plan network Requires you to pay the total cost of services if you obtain care outside the HMO's provider network without a referral from the health plan (<i>except for emergency and urgent care services</i>) 	<ul style="list-style-type: none"> Encourages you to seek services from preferred providers to ensure your coinsurance and co-payments are counted toward your calendar year out-of-pocket maximums² Allows you the option of seeing non-preferred providers, but requires you to pay a higher percentage of the bill³
Paying for services	<ul style="list-style-type: none"> Requires you to make a small co-payment for most services 	<ul style="list-style-type: none"> Limits the amount preferred providers can charge you for services Considers the PPO plan payment plus any deductibles and co-payments you make as payment in full for services rendered by a preferred provider

1. Your PCP may be part of a medical group that has contracted with the health plan to perform some functions, including treatment authorization, referrals to specialists, and initial grievance processing.
2. Once you meet your annual deductible and co-insurance, the plan pays 100 percent of medical claims for the remainder of the calendar year; however, you will continue to be responsible for co-payments for physician office visits, pharmacy, and other services, up to the annual out-of-pocket maximum.
3. Non-preferred providers have not contracted with the health plan; therefore, you will be responsible for paying any applicable member deductibles or coinsurance, plus any amount in excess of the allowed amount



Rates

Group Insurance Plan – Health, Dental and Vision

Employees and their qualified dependents become eligible on the first day of the month following month of hire.

Insurance Plan	Monthly		
	Single	2-Party	Family
Medical Rates			
Region 2 - Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, San Diego, San Luis Obispo, Santa Barbara, Tulare and Ventura			
Anthem Select	\$674.69	\$1,349.38	\$1,754.19
Anthem Traditional	\$1,046.04	\$2,092.08	\$2,719.70
Blue Shield Access+	\$938.96	\$1,877.92	\$2,441.30
Blue Shield Trio	\$722.56	\$1,445.12	\$1,878.66
Health Net Salud y Más	\$458.66	\$917.32	\$1,192.52
Health Net SmartCare	\$769.11	\$1,538.22	\$1,999.69
Kaiser CA	\$669.77	\$1,339.54	\$1,741.40
Sharp	\$632.27	\$1,264.54	\$1,643.90
UnitedHealthcare	\$723.84	\$1,447.68	\$1,881.98
PERS Choice	\$783.19	\$1,566.38	\$2,036.29
PERS Select	\$476.92	\$953.84	\$1,239.99
PERSCARE	\$1,115.68	\$2,231.36	\$2,900.77
PORAC	\$749.00	\$1,499.00	\$1,960.00
Region 3 - Los Angeles, Riverside and San Bernardino			
Anthem Select	\$639.10	\$1,278.20	\$1,661.66
Anthem Traditional	\$984.21	\$1,968.42	\$2,558.95
Blue Shield Access+	\$834.88	\$1,669.76	\$2,170.69
Blue Shield Trio*	\$660.49	\$1,320.98	\$1,717.27
Health Net Salud y Más	\$412.88	\$825.76	\$1,073.49
Health Net SmartCare	\$691.48	\$1,382.96	\$1,797.85
Kaiser CA	\$669.84	\$1,339.69	\$1,741.60
UnitedHealthcare	\$720.89	\$1,441.78	\$1,874.31
PERS Choice	\$761.23	\$1,522.46	\$1,979.20
PERS Select	\$459.94	\$919.88	\$1,195.84
PERSCARE	\$1,036.07	\$2,072.14	\$2,693.78
PORAC	\$725.00	\$1,450.00	\$1,894.00

* Blue Shield Trio is only available in select locations. Ensure your zip code and provider are participating prior to selecting this plan.

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2021 Rates: Full-Time Employees (continued)

Group Insurance Plan – Health, Dental and Vision (continued)

Employees and their qualified dependents become eligible on the first day of the month following month of hire.

Insurance Plan	Monthly			Semi-Monthly		
	EE only	EE+1	Family	EE only	EE+1	Family
Dental Rates						
MetLife DHMO	\$16.82	\$33.64	\$49.59	\$8.41	\$16.82	\$24.80
MetLife DPPO	\$44.29	\$88.75	\$127.38	\$22.15	\$44.38	\$63.69

Insurance Plan	Monthly			Semi-Monthly		
	EE only	EE+1	Family	EE only	EE+1	Family
Vision Rates						
EyeMed	\$8.03	\$15.36	\$22.60	\$4.02	\$7.68	\$11.30
UHC Spectera	\$4.66	\$4.66	\$4.66	\$2.33	\$2.33	\$2.33

Group Term Life		
	Monthly	Semi-Monthly
\$6,000	\$1.53	\$0.77
\$12,000	\$3.06	\$1.53
\$25,000	\$6.38	\$3.19
\$50,000	\$12.75	\$6.38

Cafeteria Contributions

The City offers a cafeteria like plan:

- Employee may select any medical health, dental, vision, group term life, and voluntary benefit options.
- Any remaining balance due will be deducted from the employee's paycheck on a semi-monthly basis.

Cafeteria Contributions		
Representation	Monthly	Semi-Monthly
City Manager/Executives/Elected Officials:	\$1,662.00	\$831.00
PMMA/POA:	\$1,661.66	\$830.83
GMMU/GU:	\$1,662.00	\$831.00

Medical - 2021 CalPERS EPO & HMO Basic Plans

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	Anthem Blue Cross	Blue Shield	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	Western Health Advantage HMO
	EPO Select HMO Traditional HMO	Access+ HMO & Access+ EPO Trio HMO	Salud y Más & SmartCare				
Calendar Year Deductible							
• Individual	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maximum Calendar Year Copay or Coinsurance (excluding pharmacy)							
• Individual	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)	\$1,500 (copay)
• Family	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)	\$3,000 (copay)
Hospital (including Mental Health and Substance Abuse)							
• Deductible (per admission)	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient Facility/Surgery Services	No Charge	No Charge	No Charge	\$15	No Charge	No Charge	No Charge
Emergency Services							
• Emergency Room Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Emergency (copay waived if admitted as an inpatient or for observation as an outpatient)	\$50	\$50	\$50	\$50	\$50	\$50	\$50
• Non-Emergency (copay waived if admitted as an inpatient or for observation as an outpatient)	\$50	\$50	\$50	\$50	\$50	\$50	\$50

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Medical - 2021 CalPERS EPO & HMO Basic Plans (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	Anthem Blue Cross	Blue Shield	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	Western Health Advantage HMO
	EPO Select HMO Traditional HMO	Access+ HMO & Access+ EPO Trio HMO	Salud y Más & SmartCare				
Physician Services (including Mental Health and Substance Abuse)							
• Office Visits (copay for each service provided)	\$15	\$15	\$15	\$15	\$15	\$15	\$15
• Inpatient Visits	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient Visits	\$15	\$15	\$15	\$15	\$15	\$15	\$15
• Urgent Care Visits	\$15	\$15	\$15	\$15	\$15	\$15	\$15
• Preventive Services	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Surgery/Anesthesia	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Diagnostic X-Ray/Lab							
	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Prescription Drugs							
• Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Retail Pharmacy (not to exceed 30-day supply)	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Generic: \$5 Brand: \$20	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50	Generic: \$5 Brand Formulary: \$20 Non-Formulary: \$50
• Retail Preferred Pharmacy Maintenance Medications	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	N/A	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100
• Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand: \$40 (31-100 day supply)	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100	Generic: \$10 Brand Formulary: \$40 Non-Formulary: \$100
• Mail order maximum copayment per person per calendar year	\$1,000	\$1,000	\$1,000	N/A	\$1,000	\$1,000	\$1,000

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Medical - 2021 CalPERS EPO & HMO Basic Plans (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	Anthem Blue Cross	Blue Shield	Health Net	Kaiser Permanente	Sharp Performance Plus	UnitedHealthcare SignatureValue Alliance	Western Health Advantage HMO
	EPO Select HMO Traditional HMO	Access+ HMO & Access+ EPO Trio HMO	Salud y Más & SmartCare				
Durable Medical Equipment							
	No Charge						
Infertility Testing/Treatment							
	50% of Covered Charges						
Occupational /Physical /Speech Therapy							
<ul style="list-style-type: none"> Inpatient (hospital or skilled nursing facility) 	No Charge						
<ul style="list-style-type: none"> Outpatient (office and home visits) 	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Diabetes Services							
<ul style="list-style-type: none"> Glucose monitors 	Coverage Varies	No Charge	Coverage Varies	No Charge	Coverage Varies	Coverage Varies	Coverage Varies
<ul style="list-style-type: none"> Self-management training 	\$15	\$15	\$15	\$15	\$15	\$15	\$15
Acupuncture							
	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)						
Chiropractic							
	\$15/visit (acupuncture/chiropractic; combined 20 visits per calendar year)						

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Medical - 2021 CalPERS PPO Basic Plans

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Calendar Year Deductible								
• Individual	\$1,000 ^{1,3}		\$500 ³		\$500 ³		\$300	\$600
• Family	\$2,000 ^{1,3}		\$1,000 ³		\$1,000 ³		\$900	\$1,800
Maximum Calendar Year Copay or Coinsurance (excluding pharmacy)								
• Individual	\$3,000 (coinsurance)	Unlimited	\$3,000 (coinsurance)	Unlimited	\$2,000 (coinsurance)	Unlimited	\$2,000	Unlimited
• Family	\$6,000 (coinsurance)	Unlimited	\$6,000 (coinsurance)	Unlimited	\$4,000 (coinsurance)	Unlimited	\$4,000	Unlimited
Hospital (including Mental Health and Substance Abuse)								
• Deductible (per admission)	N/A		N/A		\$250		N/A	
• Inpatient	20% ²	40% ⁴	20%	40% ⁴	10%	40% ⁴	20%	20% ⁴
• Outpatient Facility/ Surgery Services	20%	40% ⁴	20%	40% ⁴	10%	40% ⁴	20%	20% ⁴
Emergency Services								
• Emergency Room Deductible	\$50 (applies to hospital emergency room facility charge only)		\$50 (applies to hospital emergency room charges only)		\$50 (applies to hospital emergency room charges only)		N/A	
• Emergency	20% (applies to other services such as physician, x-ray, lab, etc.)		20% (applies to other services such as physician, x-ray, lab, etc.)		10% (applies to other services such as physician, x-ray, lab, etc.)		20%	
• Non-Emergency	20%	40%	20%	40%	10%	40%	50% (for non-emergency services provided by hospital emergency room)	
	(payment for physician charges only; emergency room facility charge is not covered)		(payment for physician charges only; emergency room facility charge is not covered)		(payment for physician charges only; emergency room facility charge is not covered)			

1 **Incentives available to reduce individual deductible (max. \$500) or family deductible (max. \$1,000) include:** getting a biometric screening (\$100 credit); receiving a flu shot (\$100 credit); getting a non-smoking certification (\$100 credit); getting a virtual second opinion (\$100 credit); and getting a condition care certification (\$100 credit).

2 Coinsurance waived for deliveries if enrolled in Future Moms Program.

3 Deductible is transferable between PERS Select, PERS Choice, and PERS Care.

4 Of the allowable amount as defined in the EOC.

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Medical - 2021 CalPERS PPO Basic Plans (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Physician Services (including Mental Health and Substance Abuse)								
• Office Visits (copay for each service provided)	\$35 ¹	40% ³	\$20 ²	40% ³	\$20 ²	40% ³	\$10/\$35 ²	20% ³
• Inpatient Visits	20%	40% ³	20%	40% ³	10%	40% ³	20%	20% ³
• Outpatient Visits	\$35	40% ³	\$20	40% ³	\$20	40% ³	20%	20% ³
• Urgent Care Visits	\$35	40% ³	\$35	40% ³	\$35	40% ³	\$35	20% ³
• Preventive Services	No Charge	40% ³	No Charge	40% ³	No Charge	40% ³	No Charge	
• Surgery/Anesthesia	20%	40% ³	20%	40% ³	10%	40% ³	20%	20% ³
Diagnostic X-Ray/Lab								
	20%	40% ³	20%	40% ³	10%	40% ³	20%	20% ³
Prescription Drugs								
• Deductible	N/A		N/A		N/A		N/A	
• Retail Pharmacy (not to exceed 30-day supply)	Generic: \$5 Formulary: \$20 Non-Formulary: \$50		Generic: \$5 Formulary: \$20 Non-Formulary: \$50		Generic: \$5 Formulary: \$20 Non-Formulary: \$50		Generic: \$10 Brand Formulary: \$25 Non-Formulary: \$45 Compound: \$45	
• Retail Preferred Pharmacy Maintenance Medications	Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		N/A	
• Mail Order Pharmacy Program (not to exceed 90-day supply for maintenance drugs)	Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$10 Preferred: \$40 Non-Preferred: \$100		Generic: \$20 Brand Formulary: \$40 Non-Formulary: \$75	N/A
• Mail order maximum copayment per person per calendar year	\$1,000		\$1,000		\$1,000		N/A	

1 Reduced to \$10 if enrolled with personal doctor.

2 \$35 for specialist visit.

3 Of the allowable amount as defined in the EOC

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Medical - 2021 CalPERS PPO Basic Plans (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet.

Benefits	PERS Select		PERS Choice		PERSCare		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Durable Medical Equipment								
	20%	40% ²	20%	40% ²	10%	40% ²	20%	20% ²
	(pre-certification required for equipment)		(pre-certification required for equipment)		(pre-certification required for equipment \$1,000 or more)			
Infertility Testing/Treatment								
	50%		50%		50%		50%	50% ²
Occupational / Physical / Speech Therapy								
• Inpatient (hospital or skilled nursing facility)	No Charge		No Charge		No Charge		\$20 occupational/speech; no charge	20% ²
• Outpatient (office and home visits)	20%	40%; Occupational therapy: 20%	20%	40%; Occupational therapy: 20%	10%	40%; Occupational therapy: 10%	\$20	20% ²
	(Pre-certification required for more than 24 visits)		(Pre-certification required for more than 24 visits)		(Pre-certification required for more than 24 visits)			
Diabetes Services								
• Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies		Coverage Varies	
• Self-management training	\$20 ¹	40% ²	\$20 ¹	40% ²	\$20 ¹	40% ²	\$20	60% ²
Acupuncture								
	\$15/visit	40% ²	\$15/visit	40% ²	\$15/visit	40% ²	\$15 (10% for all other services)	20% ²
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)			
Chiropractic								
	\$15/visit	40% ²	\$15/visit	40% ²	\$15/visit	40% ²	\$15/up to 20 visits	20% ²
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)			

¹ 35 for specialist visit.

² Of the allowable amount as defined in the EOC

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Obtaining Health Care Quality Information

Following is a list of resources you can use to evaluate and select a doctor and hospital.

Hospitals

CalQualityCare
www.CalQualityCare.org

From hospitals to home care, [CalQualityCare.org](http://www.CalQualityCare.org) makes it easy to find providers and compare the quality of health care in California.

U.S. Department of Health and Human Services
www.medicare.gov/hospitalcompare

Hospital Compare has information about the quality of care at over 4,000 Medicare-certified hospitals across the country.

The Leapfrog Group
www.leapfroggroup.org

This is a coalition of health purchasers who have found that hospitals meeting certain standards have better care results.

Doctors and Medical Groups

Medical Board of California
www.mbc.ca.gov

This is the California State agency that licenses medical doctors, investigates complaints, disciplines those who violate the law, conducts physician evaluations, and facilitates rehabilitation where appropriate.

Have you done a checkup on your doctor's license? The Medical Board of California encourages consumers to check up on their doctor's license. Such a checkup is simple and helps you make an informed choice when choosing a doctor. To determine a doctor's status, go to the Medical Board's website at www.mbc.ca.gov or if you do not have a computer, call 800.633.2322 and Medical Board staff will look up the doctor for you.

Office of the Patient Advocate
www.opa.ca.gov

This website includes a State of California-sponsored "Report Card" that contains additional clinical and member experience data on HMOs, PPOs and medical groups in California.



Benefit Comparison Charts

The benefit comparison charts on pages 15–21 summarize the benefit information for each plan.

For more details, see each plan's Evidence of Coverage (EOC) booklet.

Dental

MetLife

Dental PPO Plan

	PPO Plan Option	
	In-Network	Out-of-Network
Annual Deductible <i>(Individual/Family)</i>	\$50 / \$150	\$50 / \$150
Waived for Preventive	Yes	No
Annual Plan Maximum	\$1,000	\$1,000
Waiting Period	None	None
Reimbursement Schedule	Based on PPO contracted fees	90th UCR
Diagnostic & Preventive	100%	100%
Basic Services	100%	100%
Major Services	50%	50%
Orthodontia Services		
<ul style="list-style-type: none"> Lifetime Plan Maximum 	\$1,500	\$1,500
<ul style="list-style-type: none"> Eligibility 	Adults and dependent children to age 26	



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Dental (continued)

MetLife Met50 HMO

The No Problem Plan

- No Deductibles
- No Annual Maximums
- No Limitations on Most Pre-Existing Conditions
- No Waiting Periods to See a Dentist

See Your Savings

Compare your costs with MetLife Met50 HMO to average dental fees:

Sample Treatment Plan	Avg. Fee*	with Met50	Your Savings
Exams	\$83	No Charge	\$83
Cleanings	\$138	No Charge	\$138
Full Mouth x-rays	\$193	No Charge	\$193
Filling, 1 Surface	\$216	No Charge	\$216
Root Canal, Single	\$1,535	\$30	\$1,505
Crown, PFM	\$1,658	\$50	\$1,608
Total	\$3,823	\$80	\$3,743

	Met50 All Employees
Diagnostic & Preventive	Various co-pays apply
Basic Services	Various co-pays apply
Major Services	Various co-pays apply
Orthodontia Services	
• Dependent Children	\$1,450
• Adults	\$1,450
• Lifetime Plan Maximum	Unlimited

* 2016 National Dental Advisory Service for 92663

Choose from Hundreds of Dentists

MetLife offers comprehensive dental benefits through hundreds of independently owned and operated dental offices conveniently located throughout California.

Specialty Coverage

All general dentists may not be capable of performing each of the services listed herein and, based upon a Member's condition, certain procedures may not be within the scope of practice or ability of a general dentist. In such a case, the general dentist will refer the Member to a MetLife participating dental specialist. Your costs for the services of a dental specialist may vary, based upon the coverage option selected by your group.

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Dental (continued)

MetLife Met50 HMO (continued)

Met50

The following is a partial list of dental services that are covered benefits, at the specified copayment, when provided by a participating MetLife general dentist. Participating dentists may be found online at www.metlife.com.

Services	Your Copayment
Preventive	
• Office visit	No Charge
• Oral examination	No Charge
• Intraoral x-rays, complete series	No Charge
• Bitewing x-rays, single film	No Charge
• Panoramic x-ray	No Charge
• Prophylaxis (teeth cleaning)	No Charge
• Topical fluoride (child)	No Charge
• Oral Hygiene	No Charge
Routine Services	
• Amalgam, One surface	No Charge
• Amalgam, Two surfaces	No Charge
• Amalgam, Three surfaces	No Charge
Restorations	
• Resin, one surface anterior	No Charge
• Resin, two surface anterior	No Charge
• Extraction, single tooth	No Charge
Oral Surgery	
• Surgical removal of erupted tooth	No Charge
• Removal of impacted tooth, soft tissue	\$10
• Removal of impacted tooth, partially bony	\$30
• Surgical incision with drainage of abscess, intraoral soft tissue	\$15
Endodontics	
• Pulp cap, direct	No Charge
• Pulp cap, indirect	No Charge
• Therapeutic pulpotomy	No Charge
• Root canal, anterior	\$45
• Root canal, bicuspid	\$70
• Root canal, molar	\$190
Periodontics	
• Gingivectomy or gingivoplasty, 4 or more contiguous teeth, per quadrant	\$35
• Scaling & root planing, per quadrant	\$12

Services	Your Copayment
Major	
• Crowns	
– Porcelain fused to base metal (not for molars)	\$50
– Porcelain fused to base metal (for molars)	\$50
• Full cast base metal	\$50
• 3/4 cast metallic	\$50
Dentures & Prosthodontics	
• Complete upper or lower denture	\$100
• Upper or lower partial denture, resin base	\$100
• Upper or lower partial denture, cast metal base with resin saddles	\$100
• Replace missing or broken teeth, complete denture, each tooth	\$10
Implants	
• Surgical placement of implant body (endosteal)	\$1,005
• Prefab. abutment (includes placement)	\$245
• Abutment supported porcelain/ceramic crown	\$685
• Abutment supported retainer, porcelain/ ceramic fixed partial denture	\$680
Orthodontics (Standard 24-month case)	
• Full-banded, upper and lower, to age 19	\$1,450
• Full-banded, upper and lower, adults	\$1,450
• Banded, upper or lower, children & adults	\$250
• Consultation	No Charge
Cosmetic Benefits	
• Tooth colored fillings, one surface, back tooth	\$25
• Labial veneer (porcelain laminate), laboratory	\$350
• Night guards, soft, includes lab fee	\$85

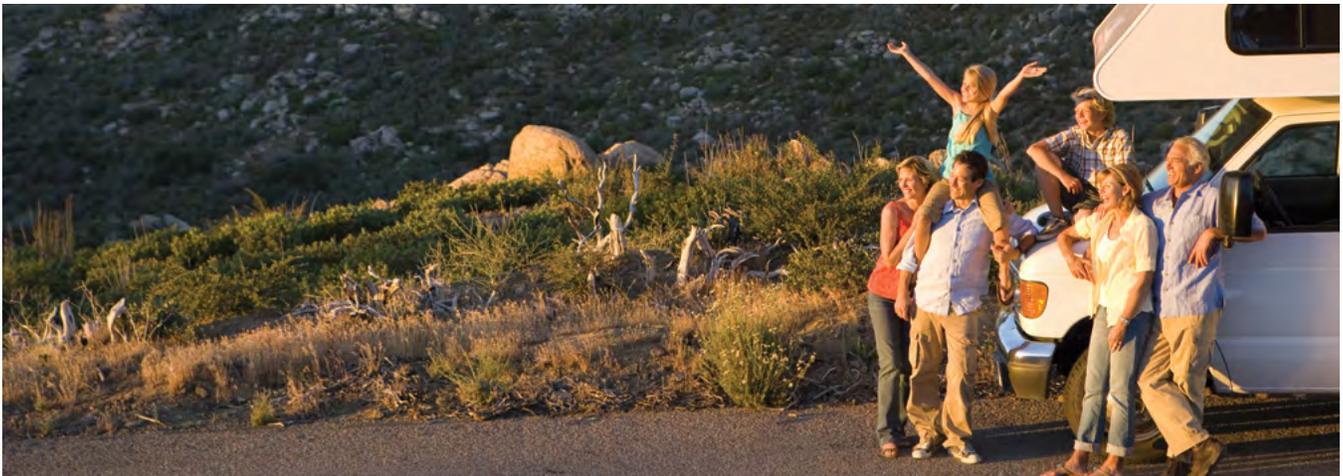
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Vision

UHC and EyeMed

	UHC Benefits (Available to General Unit employees only)		EyeMed	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Co-pay				
• Examination	0 co-pay	Up to \$40	\$10 co-pay	Up to \$47
• Materials	0 co-pay	Varies by Lens	\$0 co-pay	Varies by Lens
Benefit Frequency				
• Examination	12 months		12 months	
• Lenses	12 months		12 months	
• Frames	12 months		12 months	
• Contacts	12 months		12 months	
Lenses				
• Single Vision Lens	0 co-pay	Up to \$40	\$0 co-pay	Up to \$48
• Bifocal Lens	0 co-pay	Up to \$60	\$0 co-pay	Up to \$69
• Trifocal Lens	0 co-pay	Up to \$80	\$0 co-pay	Up to \$85
• Lenticular	0 co-pay	Up to \$80	\$0 co-pay	Up to \$125
Contact Lenses				
• Medically Necessary	0 co-pay	Up to \$210	\$0 co-pay	Up to \$210
• Elective	\$105 allowance	Up to \$105	\$150 allowance; 15% off balance over \$150	Up to \$150
Frames	\$150 allowance	Up to \$45	\$150 allowance; 20% off balance over \$150	Up to \$105

Remember with EyeMed employees and dependents have access to Freedom Pass! Freedom Pass allows employees and dependents purchasing frames at Target Optical to receive an unlimited frame allowance. Note in order to access benefit employees and/or dependents must present their "buck slip" with coupon code, see HR for a Freedom Pass.



The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Basic Life & AD&D

Basic Life

The City of El Monte provides full-time employees with the option to enroll in Basic Life and Accidental Death and Dismemberment Insurance at the employee's cost. Coverage options range from \$6,000 to \$50,000, with no medical history required.

Life and Accident Insurance

Life insurance can provide your dependents with a lifetime of financial security, and upon your death, can be used to pay off your debts- like credit cards and your mortgage - or other expenses that could burden your family.

What is Accidental Death & Dismemberment Insurance?

It is similar to regular Life insurance. If you die in an accident, your beneficiary will receive the amount of your AD&D coverage in addition to your Life Insurance benefit. Part of the benefit may be paid to you if you lose a limb or the ability to see. For more information about accident insurance, please see your Summary Plan Description.

Don't Forget to Name a Beneficiary

A beneficiary is the person or persons who will be paid if you die while covered by the plan. A person becomes your beneficiary only if you have named them when you enrolled. If you are married and not naming your spouse as the beneficiary, the spouse must sign an acknowledgement. You may change your beneficiary at any time by completing the change on the BenefitBridge website.



The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Basic Life & AD&D (continued)

Basic Life and AD&D - Paid for by the Employee

	The Hartford All Employees	Monthly
Life and AD&D		
• Employee		
– Class 1:	\$6,000	\$1.53
– Class 2:	\$12,000	\$3.06
– Class 3:	\$25,000	\$6.38
– Class 4:	\$50,000	\$12.75
Dependent Life (Optional)		
• Spouse	\$1,500	\$0.60
• Child (cost is per covered child)	\$1,500	\$0.60
• Applies to Both Life and AD&D	No	N/A
Reduction of Benefits		
• Age 70 and Older	50%	N/A

Additional Life & AD&D - Paid by the Employee

	The Hartford All Employees
Life/AD&D Benefit Amount	
• Employee	Multiples of \$5,000 to \$500,000
• Spouse	Multiples of \$5,000 to \$250,000 (not to exceed employee's benefit)
• Child	Increments of \$5,000 up to \$10,000
Reduction of Benefits	
• Age 70 and Older	50%



The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

457 Deferred Compensation Plan

The City of El Monte's 457 Plan offers you the opportunity to defer a specific amount of your paycheck on a pretax basis through a payroll deduction. It's a great way to save for your retirement years! Taxes are deferred until withdrawal. Like a 401(k), your money grows tax deferred until retirement when it is taxed as ordinary income when withdrawn.

Nationwide Retirement Solutions

Guadalupe (Lupita) Ayala | 818.798.8159 | ayalag2@nationwide.com | www.NFSforu.com

CalPERS Retirement System

Service Retirement

Your retirement formula is determined by your employer's contract with CalPERS. Your benefit factor is the percentage of pay to which you are entitled for each year of service. It is determined by your age at retirement and the retirement formula that was contracted by the City of El Monte with CalPERS. Contact your Human Resources or CalPERS to determine your retirement formula.

Retirement Formulas

	Tier I*	Tier II**
Local Miscellaneous	2% @ 55	2% @ 62
Local Safety	3% @ 50	2.7% @ 57

* Annuity based on employee's highest paid year

** Annuity based on average of employee's three (3) highest paid consecutive years

California Public Employees' Retirement System

1.888.225.7377 | www.calpers.ca.gov

Public Agency Retirement System (PARS)

Service Retirement

Unit employees hired on or before July 1, 2008 may be eligible to participate in PARS. The PARS benefit is for City of El Monte service only. In order to be eligible for the PARS benefit, the employee must have at least five (5) years' service as a regular employee of the City of El Monte and retire immediately thereafter. This supplemental retirement benefit provides a "3% @ 55" Formula through a "1% @ 55" formula furnished by PARS, coupled with the "2% at 55" formula furnished by CalPERS.

Retirement Formulas

	Tier I
Local Miscellaneous	1% @ 55

Public Agency Retirement System (PARS)

800.731.7884 | www.pars.org

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Flexible Spending Accounts

Flexible Spending Accounts are great cost savings tools to help with common medical expenses not covered by your major medical insurance and/or dependent care expenses. You can elect a portion of your pay to be deducted, on a pre-tax basis, from each paycheck to use for reimbursement of qualified out-of-pocket expenses throughout the plan year.

Flexible Spending Account Savings Example

With FSA		Without FSA
\$30,000	Annual Gross Income	\$30,000
- \$2,400	Healthcare FSA Election	\$0
- \$2,500	Dependent Care Account Election	\$0
\$25,100	Taxable Gross Income	\$30,000
- \$5,020	Estimated Federal Tax (20%)	- 6,000
- \$1,920.15	Estimated FICA (7.65%)	- 2,295
\$18,159.85	Annual Net Income	\$21,705
\$0	Cost of Medical Expenses	- \$2,400
\$0	Cost of Dependent Care Expenses	- \$2,500
\$18,159.85	Spendable Income	\$16,805
With an FSA, potential annual savings in this example is: \$1,354.85		
By using an FSA to pay for eligible expenses, you can reduce your taxable income which will result in additional spendable income.		

Healthcare Flexible Spending Account (Healthcare FSA)

A Healthcare FSA allows you to allocate money on a pre-tax basis to reimburse yourself for qualified medical expenses for you and your family. Qualified expenses include anything from co-payments, medical deductibles, prescriptions and much more.

- **Minimum Annual Election:** Determined by your employer
- **Maximum Annual Election:** Internal Revenue Code allows up to \$2,750 per plan year, but your employer will determine amount.

Examples of Eligible Expenses for Healthcare FSA

- Copays/coinsurance Deductibles
- Dental treatments
- Diabetic supplies
- Prescription drugs and medicines
- Eye exams, eyeglasses, contact lenses, contact lens solution and enzyme Flu shots
- Immunizations
- Lab fees
- Laser/Lasik/RK surgery
- Medical exams
- Orthodontia
- Psychiatric care
- Wheelchair
- X-rays

For a more complete list of eligible expenses, please visit www.americanfidelity.com.

American Fidelity (continued)

Benefits Debit Card

American Fidelity will provide a Benefits Debit Card to all employees who elect to participate in a Healthcare FSA (where offered by your employer.) The debit card gives immediate, convenient access to Healthcare FSA funds at the point of sale for prescriptions, copays, and other common qualified medical expenses. The card can only be used for the Healthcare FSA and is not available for the DCA.

Using Your Benefits Debit Card

Simply swipe your card like you would with any other credit card. Whether at the doctor's office or the dentist, the amount of your eligible expenses will be automatically deducted from your Healthcare FSA. Save ALL receipts!

Cards for Healthcare FSAs can be used at:

- Health care related facilities which include:
 - Hospitals, physician offices, dental offices, vision offices; **and**
 - Merchants participating in the Inventory Information Approval System (IIAS).
- The card is for medical expenses only; dependent day care expenses are not eligible.
- The card cannot be used for over-the-counter drugs filled with a prescription. You will need to file a manual claim for these types of expenses.

Snap. Submit. And Go!

When using your Benefits Debit Card to pay for an eligible expense, you may need to retain documentation to verify the expense. The AFmobile® app makes this easy.

- Snap a photo of the itemized receipt* with your phone.
- Submit the photo of the itemized receipts within the app when you receive notification that a receipt is needed to verify your expense.
- Go! After submitting your verification and its review, you will be able to view the status of your reimbursement within the app.

* The Internal Revenue Code (IRC) requires proof of the eligible expenses using itemized receipts or other documentation showing the date of service, person for whom service was provided and description of the expense. Depending on the type of expense, documentation may come in the form of third party itemized statements or Explanation of Benefits.



Activating Your Card

You will receive your card at your home address and may begin using your card on the first day of your plan year. Your card will be automatically activated when you use it for the first time for an eligible expense.

Dependent Care Account (DCA)

A Dependent Care Account allows you to allocate money on a pre-tax basis to reimburse yourself for dependent care expenses that allow you (and your spouse) to work. Reimbursement is permitted only after the services have been provided and the expense has been paid. As dependent care contributions are withheld from your paycheck and placed into the account, these funds become available for reimbursement requests. Submit the entire amount of your dependent care expense after the care is provided, even if it exceeds your monthly contribution amount, to maximize reimbursement opportunities. This allows you to build up a "pool" of submitted expenses, with pending amounts ready for reimbursement as soon as your next contribution is received and deposited into your account.

- **Minimum Annual Election:** Determined by your employer.
- **Maximum Annual Election:** While the IRC allows a maximum of \$5,000 per year, the employer may set the maximum equal to or lower than this amount.

American Fidelity (continued)

Examples of Eligible Dependent Care Expenses

- After-school care or extended day programs Nanny expenses
- Baby-sitter inside or outside participant's household
- Custodial or elder care expenses if the qualifying individual still spends at least 8 hours each day in the employee's household
- Dependent Day Care center* expenses pre-kindergarten/nursery school expense
- Expenses paid to a non-dependent relative of participant to care for the child
- Summer day camp if the primary purpose of the expense is custodial in nature and not educational

* A Dependent Care Center is a place that provides care for more than six persons (other than persons who live there) and receives a fee, payment or grant for providing services for any of those persons, regardless of whether the center is run for profit.

Regardless of whether you participate in the Dependent Care Account under the Section 125 Plan or claim the Dependent Care credit on your income tax return, you must provide the Internal Revenue Service with the name, address and taxpayer identification number (TIN) or Social Security number of your dependent care provider(s) by completing either Schedule 2 of Form 1040A or Form 2441 and the current instructions given by the IRS for preparing your annual income tax return. Failure to provide this information to the IRS could result in loss of the pre-tax treatment of your Dependent Day Care FSA contributions or loss of the Dependent Care Tax Credit.

FSA Fund Availability

Healthcare FSA

Your full annual election is available to you on the first day of the plan year.

Dependent Care Account

Unlike the Healthcare FSA, the entire elected amount is not available on the first day of the plan year, but rather as contributions are received.

Important FSA Notes:

- Participants are generally allowed a 90-day run-off period after the plan year ends to submit claims for expenses that occurred during the plan year but were not yet submitted.
- If you are a new employee entering the FSA during a plan year, reimbursement is only available for expenses and services provided after you begin your participation in the FSA.
- If you are enrolled in the Healthcare FSA and take a leave of absence during the plan year, you may (subject to your employer's plan):
 1. Prepay the contributions on a pre-tax basis, **or**
 2. Continue the contributions by remitting them to your employer. Pre-tax contributions may continue if you continue to receive enough pay, **or**
 3. Prorate the unpaid contributions over the remaining pay periods when you return to work.
- Failure to make all elected contributions will result in termination of your account as of the date contributions ceased.
- Healthcare FSAs must comply with COBRA and generally must offer COBRA continuation rights to qualified beneficiaries who lose Healthcare FSA coverage due to certain qualifying events. For most Healthcare FSAs, COBRA may be offered upon a qualifying event only if you have a balance remaining in your Healthcare FSA. The balance is generally calculated by subtracting the reimbursements made prior to the qualifying event from the annual election. If eligible, you may choose to continue your contributions by either sending your contributions to your employer on an after-tax basis each pay period, or, you may choose to make a pre-tax contribution for your remaining elections for the plan year from your final pay or severance pay. Expenses incurred while contributions are being made are eligible for reimbursement. Coverage generally may not continue beyond the current plan year. If you do not elect COBRA, only expenses incurred during the period of employment are reimbursable. Coverage under the Healthcare FSA ceases when the contributions cease.

American Fidelity (continued)

File a Claim

Three Easy Ways

1. **On your mobile device using AFmobile®**
Use AFmobile to manage your reimbursement accounts and insurance benefits.
2. **Online at americanfidelity.com**
3. **By mail or fax:**
Insurance Claim
American Fidelity Assurance Company
Attn: Benefits Department
P.O. Box 268898
Oklahoma City, OK 73125
Fax: 800.818.3453
FSA and HRA Claim
American Fidelity Assurance Company
Attn: Flex Account Administration
P.O. Box 161968
Altamonte Springs, FL 32716
Fax 844.319.3668

* Obtain a claim form for your insurance claim at www.americanfidelity.com/fileclaim.



Manage Your Reimbursement Account With AFmobile®

AFmobile® allows FSA and HRA participants to submit reimbursement account claims while on the go.

- **Access accounts** – check balances, view transaction history, and more.
- **Manage claims** – submit new claims, upload receipts, and check claims status.
- **Receive account alerts** – choose to receive account updates by text and push notifications.
- **Submit documentation** – tie receipts and other documentation to a pending card swipe to expedite adjudication.

Getting Started:

Download AFmobile. To register, you will need:

- Your email address - this should be the same email address provided at time of enrollment.
- Your Social Security Number.

Using Our Online Portal

Our online portal provides all the same great features as mobile, plus powerful self-service account access and education resources to help put you in the driver's seat.

Getting started:

- Register at americanfidelity.com
- Register using your email address and Social Security Number
- Once completed, access your reimbursement accounts and insurance benefits.

Direct Deposit

By enrolling in direct deposit, you can ensure a timely reimbursement! You will no longer need to worry about having to wait on checks or make any more trips to the bank.

Three ways to sign up for direct deposit:

1. Through your mobile app.
2. Online through your account at americanfidelity.com
3. By downloading a direct deposit request form

American Fidelity (continued)

Short-Term Disability Income Insurance

How do you pay for your mortgage, bills, food and other monthly expenses? If your paycheck stopped today, could you maintain your current lifestyle?

American Fidelity's Short-Term Disability Income Insurance is designed to help protect you if you become disabled and cannot work due to a covered Accidental Injury or Sickness.

How the Plan Works

If you become disabled due to a covered accident or sickness, Short-Term Disability Income Insurance will pay the disability benefit once you have satisfied the elimination period. Your benefit amount is dependent on your salary and the amount you select at the time of application. Disability benefits will be payable up to the benefit period stated in your policy.

Benefits Begin (Elimination Period)

For the Short-Term Disability Income plan, benefits can begin on the eighth day - 181st day, depending on the plan selected at the time of application. Benefits are payable for a covered Injury or Sickness up to 90 days or 180 days, based on the plan your employer has selected. Refer to your employer's plan and your Certificate for details regarding benefit amounts and more.

Eligibility

All full-time employees and employees of members on active service working 25 hours or more per week. Applicant's eligibility for this program may be subject to insurability. It is your responsibility to see the American Fidelity representative once you have satisfied your employer's waiting period.

Coverage Feature	What It Means To You
Benefit Paid Directly to You, Regardless of Other Coverage	Use the money however best fits your financial needs, regardless of other insurance.
Age at Entry	Your premiums will be based on the date your policy becomes effective.
Accidental Death Benefit	Receive a benefit if you die as the direct result of an Accidental Injury and death occurs within 90 days after the date of the Accidental Injury.
Competitive Premiums	Your monthly premiums could be paid with only one hour of a week's paycheck.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.
Physician Benefit	Receive a benefit if you receive treatment by a Physician due to a covered Injury.
Accidental Death Benefit	Receive a benefit if death occurs as a direct result of an Injury within 90 days after the Injury.
Guaranteed Issue	First-time eligible employees may be able to receive coverage without being subject to insurability.
Age at Entry Premiums	Premiums will be based on the date your policy becomes effective.

*Limitations, exclusions, and waiting periods apply. Refer to your policy for complete details. **This product is inappropriate for people who are eligible for Medicaid coverage.***

American Fidelity (continued)

Accident Only Insurance

Limited Benefit Accident Only Insurance

Whether a weekend warrior with an active lifestyle or just a busy family, accidents can happen anytime, anywhere, without warning. Being prepared for the unexpected can make all the difference.

American Fidelity's Accident Only Insurance policy provides you a solution for those unforeseen accidents that life sometimes delivers. Our Limited Benefit Accident Only Insurance is designed to help pay for the unexpected medical expenses an individual may incur for the treatment of covered injuries received in an accident.

How the Plan Works

Our Accident Only Insurance policy pays according to a wide-ranging schedule of benefits. In addition, the policy provides 24-hour coverage for accidents that occur both on and off the job.

All benefits are only paid as a result of Injuries received in an Accident that occurs while coverage is in force. All treatment, procedures, and medical equipment must be diagnosed, recommended and treated by a Physician. All benefits are paid once per Covered Person per Covered Accident unless otherwise specified in the Limitations and Exclusions section.

Optional Rider

Enhance your base plan with the following rider:

- Accident Benefit Enhancement Rider

Coverage Feature	What It Means For You
Plan Options: Basic, Enhanced, and Enhanced Plus	Choose the plan to meet your financial needs.
Four Choices of Coverage: Individual, Individual and Spouse, Individual and Child, or Family	Your premiums will be based on the date your policy becomes effective. Choose the coverage that fits your lifestyle.
Wide-Ranging Schedule of Benefits	Covers all types of covered injuries.
Wellness Benefit	The plan pays an annual Wellness Benefit for one Covered Person to receive a routine physical exam, including immunizations and preventative testing.
Accident Emergency Treatment Benefit	Receive a benefit when emergency treatment in a Physician's office or emergency room occurs within 72 hours of a covered accident.
Benefit Paid Directly to You, to use as you see fit	Use the benefit however best fits your financial needs.
Guaranteed Renewable	Keep your coverage as long as premiums are paid as required.
24-Hour Coverage	You are covered on or off the job.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Additional Coverage Options	Enhance the base plan by adding an optional rider.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

*Limitations, exclusions and waiting periods apply. Refer to your policy for complete details, AO-03 series with AMDI258 rider. **This product is inappropriate for people who are eligible for Medicaid coverage.** The premium and amount of benefits provided vary dependent upon the plan selected. The company has the right to change premiums by class. Availability of riders may vary by state.*

American Fidelity (continued)

Cancer Insurance

Limited Benefit Cancer Insurance Policy

A cancer diagnosis may be overwhelming. Even with a good medical plan, the out-of-pocket costs of cancer treatment, such as travel, childcare, and loss of income, are considerable and may not be covered.

American Fidelity Assurance Company's Cancer Insurance offers a solution to help you focus your attention on fighting cancer. We offer plans that can help assist with out-of-pocket costs often associated with a cancer diagnosis.

How the Plan Works

Our plan is designed to help cover expenses if you are diagnosed with a covered Cancer. With over 20 benefits available to you, this plan provides benefits for the treatment of cancer, transportation, hospitalization and more. We provide the benefit directly to you, to be used however you see fit.

Optional Riders

Enhance your base plan with the following riders:

- **Critical Illness Rider** – Includes a cancer benefit and a heart attack/stroke benefit
- Hospital Intensive Care Unit Rider

Coverage Feature	What It Means For You
Plan Options: Basic, Enhanced and Enhanced Plus	Choose the plan to meet your financial needs.
Three Choices of Coverage: Individual, Single Parent Family, or Family	Choose the coverage that fits your lifestyle.
Wide-Ranging Schedule of Benefits	Covers a wide range of treatments.
Benefit Paid Directly to You	Use the money however best fits your financial needs.
Guaranteed Renewable	Policy is guaranteed renewable as long as premiums are paid as required.
Diagnostic and Prevention Benefit	Receive a benefit for visiting your doctor for a cancer screening test, which helps with early detection.
Transportation and Lodging	Receive benefits if you travel more than 50 miles from your home using the most direct route for covered treatment.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Additional Coverage Options	Enhance the base plan by choosing from a selection of optional riders.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

*Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. **This product is inappropriate for people who are eligible for Medicaid coverage.** The company has the right to change premiums by class. The premium and amount of benefits provided vary dependent upon the plan selected.*

American Fidelity (continued)

Group Critical Illness Insurance

Limited Benefit Group Critical Illness Insurance Policy

Surviving a critical illness, such as a heart attack or stroke, can come at a high price. With advances in technology to treat these diseases, the cost of treatment rises more and more every year. Even with medical insurance, the out-of-pocket expenses associated with a critical illness can affect anyone's finances.

American Fidelity Assurance Company's Limited Benefit Group Critical Illness Insurance can be the solution that helps you and your family focus on recovery, and may help you with paying bills. Our plan can assist with the expenses that may not be covered by major medical insurance.

How the Plan Works

If you are diagnosed with a covered Critical Illness, such as a heart attack or stroke, this plan is designed to pay a lump sum benefit amount to help cover expenses. Also, this plan offers a Recurrent Diagnosis Benefit for certain specified Critical Illnesses that provides an additional 50% of the Critical Illness benefit amount after the second occurrence date. Covered Critical Illness events include Heart Attack, Permanent Damage Due to a Stroke, and Major Organ Failure.

Guaranteed Renewable

You are guaranteed the right to renew your base policy until age 75 as long as you pay premiums when due or within the premium grace period. The insurer has the right to increase premium rates if the policy so provides.

Coverage Feature	What It Means For You
Plan Options: Basic, Enhanced and Enhanced Plus	Choose the plan to meet your financial needs.
Three Choices of Coverage: Individual, Single Parent Family, or Family	Choose the coverage that fits your lifestyle.
Wide-Ranging Schedule of Benefits	Covers a wide range of treatments.
Benefit Paid Directly to You	Use the money however best fits your financial needs.
Guaranteed Renewable	Policy is guaranteed renewable as long as premiums are paid as required.
Diagnostic and Prevention Benefit	Receive a benefit for visiting your doctor for a cancer screening test, which helps with early detection.
Transportation and Lodging	Receive benefits if you travel more than 50 miles from your home using the most direct route for covered treatment.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Additional Coverage Options	Enhance the base plan by choosing from a selection of optional riders.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. This product is inappropriate for people who are eligible for Medicaid coverage. Group Critical Illness is only offered on an after-tax basis.

American Fidelity (continued)

Mobile Convenience

For ultimate convenience, get 24/7 access, direct from your tablet or mobile device with AFmobile®. Our mobile application allows you to manage your reimbursement accounts and insurance benefits, all from the palm of your hand.

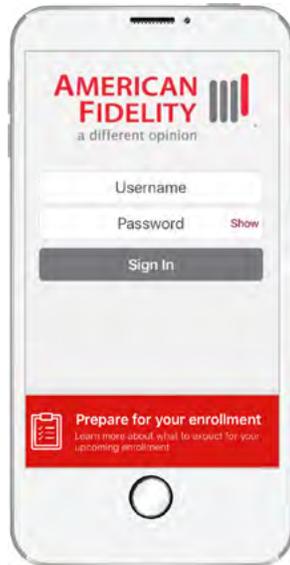
AFmobile Features

- Manage claims
- Receive account alerts
- Maintain personal information
- View account balance
- Prepare for enrollment
- Submit receipt documentation

Getting started:

- Download AFmobile on your smart device.
- Register using your last name, Social Security Number, and email address.
- Your email address should be the same email address provided at time of enrollment.

If you already have an online account, your username and password will be the same for AFmobile.



Online Control

From your laptop or desktop, access all of your American Fidelity accounts - reimbursement accounts and insurance benefits - from one portal.



Getting started:

- Visit americanfidelity.com and click on the Login button.
- Register using your last name, Social Security Number, and email address.
- Your email address should be the same email address provided at time of enrollment.

File a Claim. Three Easy Ways.

1. Mobile

- Use AFmobile to manage your reimbursement accounts and insurance benefits.

2. Online

- Log in to your account by visiting americanfidelity.com and clicking on the Login button.

3. Mail or fax

- Download a claim form at americanfidelity.com/forms. Follow the instructions on the form to mail or fax to us.

Please allow one business day after you enroll before registering for your account.

Employee Assistance Program

MHN (Paid for by the City)

MHN Employee Assistance Program (EAP) All Employees	
Number of Visits	3 sessions per person per incident
Included Services	3 face-to-face counseling session per issue on the following topics:
	<ul style="list-style-type: none"> • Depression, anxiety and stress • Substance abuse • Relationship problems • Workplace conflicts • Home maintenance referrals • Living with chronic health conditions • Child and elder care and more
	60 minute initial telephonic consultation per financial issue; with unlimited follow-up telephonic consultations on the following topics:
	<ul style="list-style-type: none"> • Budgeting • Debt/credit management • Retirement planning • Saving for college • Mortgage and auto loans • Bankruptcy and more
	60 minute in-person or telephonic consultation per legal issue on the following topics:
	<ul style="list-style-type: none"> • Family conflicts, divorce or alimony • Landlord/tenant disputes • Wills, estates and Power of Attorney • Bankruptcy • IRS concerns • Consumer and small claims matters • DUI and other criminal cases

The challenges you face each day can overwhelm you. Your home life, your happiness and your performance at work all can suffer. We can help. Your Employee Assistance Program (EAP) and WorkLife Services Benefit provides confidential support for those everyday challenges, and for more serious problems. It's available around the clock anytime you need it.

How to Use the EAP

Follow these simple steps to access EAP services:

1. Call the toll-free number at 800.227.1060, 24 hours a day, 7 days a week.
2. You will be connected with a licensed EAP counselor who will help you determine the most appropriate type of assistance to resolve your concerns.
3. If the resources required are beyond the scope of the EAP, the employee assistance counselor can refer you to additional services available through your insurance plan or community-based services.

The Hartford Life Insurance Assistance

BENEFICIARY ASSIST® COUNSELING SERVICES



GETTING THROUGH A LOSS IS HARD. GETTING SUPPORT TO COPE IS EASY.

The loss of a loved one can leave you feeling overwhelmed. In addition to grief, you may have financial and legal worries. Questions you can't easily answer alone. And maybe some unresolved issues. If you're covered under The Hartford's **Group Life or Accident insurance policy**, you have access to Beneficiary Assist® counseling services provided byComPsych.¹

PROFESSIONAL HELP AFTER A LOSS OR TERMINAL ILLNESS.

Beneficiary Assist provides you, your eligible beneficiaries and immediate family members with unlimited 24/7 phone access to help related to the death of yourself or a loved one. That includes:

- Legal advice, financial planning and emotional counseling for up to one year from the date the claim is filed.

- Up to five face-to-face sessions or equivalent professional time for one service or a combination.

HANDLING A SPECTRUM OF NEEDS WITH COMPASSION AND EXPERTISE.

Because Beneficiary Assist covers a spectrum of concerns, you and your beneficiaries will have a convenient, single source for the following needs. Emotional or grief counseling. ComPsych GuidanceExpertsSM are master's and doctoral level clinicians who'll listen to your concerns with compassion and refer you to the right resources for:

- Grief and loss.
- Stress, anxiety and depression.
- Relationship/marital conflict.
- Problems with children.
- Job pressures.
- Substance abuse.

continued



The Hartford Life Insurance Assistance (continued)

BENEFICIARY ASSIST® COUNSELING SERVICES



CASE ILLUSTRATION: SOLID FOOTING.²

Greg's sudden death at the age of 42 came as an enormous blow to his wife, Sharon. Besides the shock and grief, Sharon had to struggle with debt and claims to Greg's estate by children from a former marriage. She went back and forth between anger and depression.

Through Beneficiary Assist, she was able to link up with counselors who listened compassionately and referred her to a grief expert. She also used the legal and financial counseling resources to get solid answers to complex questions.

FINANCIAL INFORMATION AND RESOURCES.

With loss often come tough financial decisions. Share your concerns with certified public accountants and certified financial planners for assistance with:

- Managing a budget.
- Estate closure.
- Retirement impacts.
- Tax questions.
- Getting out of debt.

LEGAL SUPPORT AND RESOURCES.

When legal uncertainties arise, get the help you need. Attorneys are available for private consultations for the following:

- Estate and probate.
- Debt and bankruptcy.
- Real estate transactions.
- Family law.

If additional legal representation is needed beyond the face-to-face visits, you can be referred to a qualified attorney in your area. You may qualify for a 25 percent reduction in the attorney's customary fees by using the ComPsych Network.

REACH OUT.

Find out more about Beneficiary Assist counseling services by calling **1-800-411-7239**. It's a service you'll be glad to have when you need it.

Prepare. Protect. Prevail.®

Visit us at THEHARTFORD.COM/EMPLOYEEBENEFITS



The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home office is Hartford, CT.

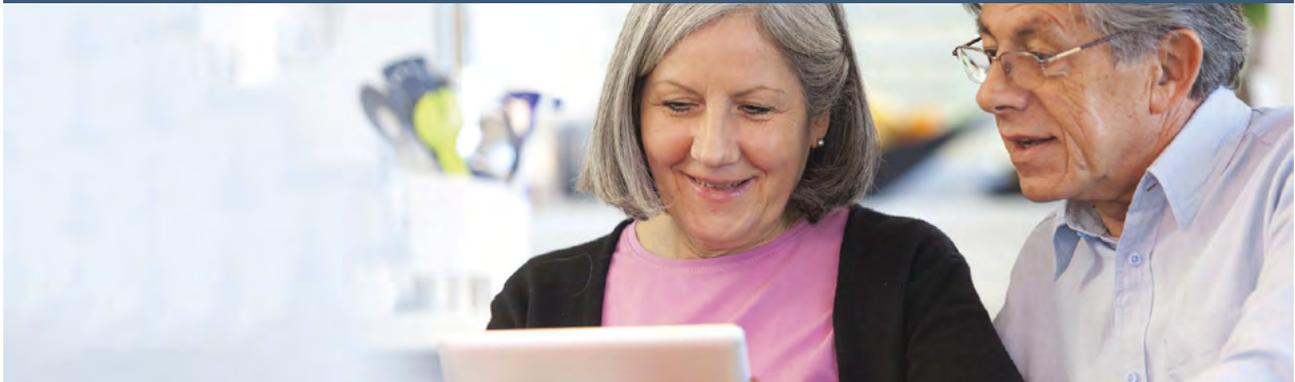
¹ Beneficiary Assist® is offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time.

² This case illustration is fictitious and for illustrative purposes only.

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The Hartford Life Insurance Assistance (continued)

ESTATEGUIDANCE® WILL SERVICES



CREATE A SIMPLE WILL FROM THE CONVENIENCE OF YOUR DESKTOP.

Whether your assets are few or many, it's important to have a will. It's the only way to ensure that your intentions will be honored in the event of your death. A will states your wishes about who will inherit your property, who will be the guardian of your children, and who will manage your estate. Without a will, those decisions may be left to others.

AN EASY AND EMPOWERING SOLUTION.

As a covered employee under a Hartford Group Life insurance policy, you have access to EstateGuidance® Will Services provided by ComPsych®.¹ It helps you create a simple, legally binding will quickly and conveniently online, saving you the time and expense of a private legal consultation. Other advantages include:

- Online assistance from licensed attorneys should you have questions.
- The ability to save drafts for up to six months. During this period, you can revise your will at no cost, as long as you haven't already printed or downloaded it.

- Additional estate planning services are also available for purchase, including the creation of living wills and trusts, guidance about divorce proceedings, and durable power of attorney.

QUICK ANSWERS TO KEY QUESTIONS.

Where there's a will, there are bound to be questions. Here are answers to four common ones.

“Isn't will preparation complicated?”

Not with EstateGuidance®. You'll be asked a series of questions online that are used to compose your will. In many states, you need only add your signature to make the will valid.

“What if I have questions as I'm creating my will?” The online education center provides answers regarding family law. You can also access fully licensed attorneys who'll respond to you online.

“What about my privacy?” All information is kept secure and confidential with the latest encryption technology.²

continued



The Hartford Life Insurance Assistance (continued)

ESTATEGUIDANCE® WILL SERVICES



CASE ILLUSTRATION: THE FINAL WORD.³

Laura was the single parent of a six-year-old daughter, Amy. She worried that if she were to die, her modest but hard-earned assets would not be available to her daughter.

The cost of a legal will seemed beyond her means until she discovered EstateGuidance® through her group life insurance provider. With it, she was able to appoint her older sister as executor of her will and name her brother and sister-in-law as Amy's legal guardians. She felt better knowing that she would have the final word in protecting her daughter's best interests.

“ So, what happens if I don't create a will?”

The state, not you, would decide how your property is distributed. In most states, all of your community and joint property would pass to your spouse if you have one. Separate property is passed according to a complex order of distribution, regardless of your loved ones' wishes. By drafting a will, you can spare them a potentially awkward and contentious situation.

GOOD INTENTIONS AREN'T ENOUGH.

You might have the best of intentions, but without a will, they aren't legally binding. Take this opportunity to put your intentions into action.

Visit

WWW.ESTATEGUIDANCE.COM/WILLS

today. Use this code: **WILLHLF**. Then follow the easy steps below:

1. Access The Hartford's EstateGuidance® Will Services online.
2. Sign in to the secure site by entering the access code.
3. Follow the instructions and create your will.
4. Download the final will to your computer and print.
5. Obtain signatures and determine if your will should be notarized.

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¹ EstateGuidance® is offered through The Hartford by ComPsych® Corporation. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych and reserves the right to discontinue any of these services at any time. A simple will does not cover credit shelter trust, printing or certain other features. These features are available at an additional cost to you.

² The EstateGuidance® website is secured with a GoDaddy.com Web Server Certificate. Transactions on the site are protected with up to 256-bit Secure Sockets Layer encryption.

³ This case illustration is fictitious and for illustrative purposes only.

Services may not be available in all states.

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The Hartford Life Insurance Assistance (continued)

FUNERAL PLANNING AND CONCIERGE SERVICES



ADDED PEACE OF MIND WHEN IT'S NEEDED THE MOST.

The death of a loved one is one of life's most stressful situations. Quick, often costly decisions must be made while emotions are at their peak. Yet, how many people know how to plan a funeral? That's why your employer offers a funeral planning and concierge service through The Hartford's **Group Life insurance program** - provided by Everest,¹ the first to offer this service nationwide.

THE RESOURCES TO HELP YOU MAKE CONFIDENT, INFORMED DECISIONS.

Everest's advisors help families understand all of their options and put them into action while staying within their budget. Here are the services they offer you, your spouse/partner and children under the age of 26.

EVEREST SERVICES

24/7 Advisor Assistance

- Round-the-clock access to Everest Advisors.
- Assistance with all funeral planning issues.

PriceFinderSM Research Reports

- The only nationwide database of funeral home prices.
- Detailed local funeral home price comparisons.
- Unlimited access to reports available on demand via the Web site.

Online Planning Tools

- Unlimited use of Everest's online planning, research, and knowledge tools.
- Create simple or detailed funeral plans using various reference materials, including 10 key decisions everyone should make.
- Information can be stored, updated, retrieved and printed on demand.

continued



The Hartford Life Insurance Assistance (continued)

FUNERAL PLANNING AND CONCIERGE SERVICES



CASE ILLUSTRATION: A SHOULDER TO LEAN ON.²

April had always thought that she and her husband would spend their golden years together. So when he began to lose his battle with pancreatic cancer, she was completely unprepared. However, April had a knowledgeable and trusted resource: Everest services were included as part of her insurance program.

Her Everest advisor assisted with every aspect of the funeral planning process, giving April peace of mind during this stressful time. And she received an expedited life insurance payment within a week of her husband's death, which helped ease many of the family's financial pressures. Everest's services relieved April of some of the stress that comes with loss, allowing her to focus on her family.

EVEREST SERVICES *con't*

At-Need Family Support

- Concierge services at or near the time of death provided by Everest's licensed funeral directors, who offer as much or as little assistance as the family desires.
- Communication of the plan with the funeral home of choice, removing the family from a sales-focused environment.
- Pricing information presented to the family in an easy-to-understand format.
- Negotiation of the funeral costs with the funeral home, often resulting in significant financial savings.

Express Claim Processing

- Includes Express Pay, an innovative claims payment service that can deliver benefits in as little as 48 hours.
- Allows your beneficiary to use the insurance proceeds to pay for immediate funeral expenses.

A TRUSTED ADVISOR DURING THE WORST OF TIMES.

We can't always predict, but we can prepare. Find out more about The Hartford's Funeral and Concierge Services by calling **1-866-854-5429**.

Or visit **WWW.EVERESTFUNERAL.COM/HARTFORD** and use this code: **HFEVLC**.

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¹ Funeral Concierge Services are offered through Everest Funeral Package, LLC (Everest). Everest and the Everest logo are service marks of Everest Funeral Package, LLC. PriceFinder is a service mark of Everest Information Services, LLC. Everest is not affiliated with The Hartford and is not a provider of insurance services. Everest and its affiliates have no affiliation with Everest ReGroup, Ltd., Everest Reinsurance Company or any of their affiliates. The Hartford is not responsible and assumes no liability for the services provided by Everest Funeral Package, LLC as described in these materials.

² This case illustration is fictitious and for illustrative purposes only.

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The Hartford Travel and ID Theft Protection

TRAVEL ASSISTANCE AND ID THEFT PROTECTION SERVICES



TRAVEL ASSISTANCE AND ID THEFT PROTECTION SERVICES.

EVEN THE BEST PLANNED TRIPS CAN BE FULL OF SURPRISES.

The best laid travel plans can go awry, leaving you vulnerable and, possibly, unable to communicate your needs. When the unexpected happens far from home, it's important to know whom to call for assistance.

If you are covered under a Hartford Group Policy, you and your family have access to Travel Assistance Services provided by Europ Assistance USA.¹

With a local presence in 200 countries and territories around the world, and numerous 24/7 assistance centers, they are available to help you anytime, anywhere.

GOOD TO GO: MULTILINGUAL ASSISTANCE 24/7.

Whether you're traveling for business or pleasure, Travel Assistance services are available when you're more than 100 miles from home for 90 days or less.^{2,3}

As long as you contact Europ Assistance USA at the time of need, you could be approved for up to \$1 million in covered services.⁴

SERVICES FROM HERE TO THERE.

Travel Assistance begins even before you embark, with pre-trip information, and continues throughout your trip. See the list of services in the chart on the back of this page.

IDENTITY THEFT ASSISTANCE, TOO.

Identity theft, America's fast growing crime, victimizes almost 10 million American consumers each year.⁵ Europ Assistance USA helps protect you and your family from its consequences 24/7,² at home and when you travel.

In addition to prevention education, this service provides advice and help with administrative tasks resulting from identity theft.

continued



The Hartford Travel and ID Theft Protection (continued)

TRAVEL ASSISTANCE AND ID THEFT PROTECTION SERVICES			
EMERGENCY MEDICAL ASSISTANCE ⁶	PRE-TRIP INFORMATION	EMERGENCY PERSONAL SERVICES ⁷	IDENTITY THEFT ASSISTANCE
<ul style="list-style-type: none"> • Medical referrals • Medical monitoring • Medical evacuation • Repatriation • Traveling companion assistance • Dependent children assistance • Visit by a family member or friend • Emergency medical payments • Return of mortal remains 	<ul style="list-style-type: none"> • Visa and passport requirements • Inoculation and immunization requirements • Foreign exchange rates • Embassy and consular referrals 	<ul style="list-style-type: none"> • Medication and eyeglass prescription assistance • Emergency travel arrangements⁹ • Emergency cash⁹ • Locating lost items • Bail advancement 	<ul style="list-style-type: none"> • Prevention Services <ul style="list-style-type: none"> - Education - Identity Theft Resolution Kit • Detection Services <ul style="list-style-type: none"> - Fraud alert to three credit bureaus • Resolution Guidance and Assistance <ul style="list-style-type: none"> - Credit information review - ID Theft Affidavit Assistance - Card replacement • Personal Services <ul style="list-style-type: none"> - Translation - Emergency cash advance*

* Cash advance available when theft occurs 100 miles or more from your primary residence. Must be secured by a valid credit card.

CASE ILLUSTRATION: HELP A WORLD AWAY.⁸

As a Human Resource Professional, Tammy had always been on the coordinating end of travel services helping her company's employees; but when her daughter was hurt while traveling with her school group in Italy, she suddenly found herself in a different position.

Using the travel assistance medical referral, medical monitoring, and repatriation services from Europ Assistance USA, Tammy's daughter was able to receive immediate medical treatment and was evacuated within 48 hours. The Europ Assistance USA Case Manager helped Tammy through some of the most stressful days she's experienced as a mother and provided care for her daughter when she couldn't.

What to have ready: Your employer's name, a phone number where you can be reached, nature of the problem, Travel Assistance Identification Number and your company policy number, which can be obtained through your Human Resources department.

Have a serious medical emergency? Please obtain emergency medical services first (contact the local "911"), and then contact Europ Assistance USA to alert them to your situation.

Call: **1-800-243-6108** Collect from other locations: **202-828-5885** Fax: **202-331-1528**

Travel Assistance Identification Number: **GLD-09012**

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¹ Travel Assistance and Identity Theft services are provided by Europ Assistance USA. Europ Assistance USA is not affiliated with The Hartford and is not a provider of insurance services. Europ Assistance USA may modify or terminate all or any part of the service at any time without prior notice. None of the benefits provided to you by Europ Assistance USA as a part of the Travel Assistance and Identity Theft service are insurance. This brochure, the Travel Assistance and Identity Theft service Terms and Conditions of Use, and the Identity Theft Resolution Kit constitute your benefit materials and contain the terms, conditions, and limitations relating to your benefits. These services may not be used for business or commercial purposes or by any person other than the individual insured under The Hartford's group insurance policy. The Hartford is not responsible and assumes no liability for the goods and services described in these materials.

² Coverage includes spouse (or domestic partner) and dependent children under age 26.

³ Services are available in every country of the world. Depending on the current political situation in the country to which you are traveling, EA may experience difficulties providing assistance, which may result in delays or even the inability to render certain services. It is your responsibility to inquire, prior to departure, whether assistance service is available in the countries where you are traveling.

⁴ The Combined Single Limit (CSL), or amount of money available to the insured under a Hartford Group policy the Travel Assistance Program, is \$1 million. One service or a combination of the services may exceed the CSL. The insured is responsible for payment of any expenses that exceed the CSL. Note: Certain Accidental Death and Dismemberment programs may offer different CSLs. Please consult with your Human Resources Manager for more details.

⁵ www.transunion.com/personal-credit/identity-theft-and-fraud/identity-theft-facts.page, viewed on 6/25/15.

⁶ In a medical emergency, Europ Assistance USA pays for assistance as described herein, but you are personally responsible for paying your medical/hospital expenses.

⁷ Europ Assistance USA provides the described personal services to you in an emergency, but you are personally responsible for the cost of air fare not approved as medically necessary by the attending physician; food, hotel and car expenses; and attorney fees. Emergency cash advances and bail advancement require your personal satisfactory guarantee of reimbursement provided through a valid credit card.

⁸ This case illustration is fictitious and for illustrative purposes only.

⁹ Emergency cash is charged as a cash advance, and emergency airline tickets are charged as a purchase to your credit card account and are all subject to that account's finance rates.

DISCLAIMER: Service Exclusions and Limitations: Europ Assistance USA (EA) services are eligible for payment or reimbursement by EA only if EA was contacted at the time of the services and arranged and/or preapproved the services. Certain terms, conditions and exclusions apply; for further information refer to the Web site listed or call EA at the number provided.

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Long Term Disability

Long Term Disability – The Standard (Paid for by the City)

	The Standard Elected Officials, Executives, PMMA, and GMMU
Benefit Percentage	Class 1 – 66 2/3% Class 2 – 66 2/3% Class 3 – 60%
Monthly Benefit Maximum	Class 1 – City Manager: \$12,500 Class 2 – Assistant City Manager and Department Directors: \$10,000 Class 3 – All Other Members: \$2,100
Minimum Monthly Benefit	\$100
Elimination Period	90 days
Definition of Disability	For the benefit waiting period and the first 24 months for which LTD benefits are paid, being unable as a result of physical disease, injury, pregnancy, or mental disorder to perform with reasonable continuity the substantial and material acts of your own occupation and you are not working in your own occupation, or you are unable to earn 80% or more of their indexed predisability earnings while working in your own occupation.
Pre-Existing Conditions Limitations	12 months for conditions treated within the 3 months prior to effective date of coverage



The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Disability & Leaves of Absence

Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act of 1993 and applicable state law (collectively, "FMLA") generally affords eligible employees: (1) the right to leave without pay for up to a maximum of 12 weeks in 12 months for qualifying circumstances; (2) continuation of health coverage during the leave period at the same cost as during active employment; (3) reinstatement of other benefits upon return from the leave; and (4) restoration of individual's position or an equivalent one upon return from leave. FMLA qualifying circumstances include time off: (1) to care for the employee's child, or placement for adoption or foster care; (2) to care for the employee's spouse, child or parent who has serious health condition; or (3) for a serious health condition that renders the employee unable to perform his/her job. The 12-month period used by the City of El Monte to determine an employee's allowable FMLA leave is the 12-month period measured backward from the date an employee's FMLA request begins.

Pregnancy Disability Leave (PDL)

All employees, regardless of how long they have been with the City are entitled to Pregnancy Disability Leave for up to four months for each pregnancy. PDL applies when a pregnant woman is disabled by pregnancy, childbirth or related medical conditions according to her health care provider. PDL occurs at the same time as FMLA.



California Family Rights Act (CFRA)

The CFRA allows for 12 weeks of unpaid leave for all of the same reasons as FMLA, except CFRA does not include pregnancy or related medical conditions within the definition of a serious health condition. This is the most significant difference between the FMLA and the CFRA. The result is that if a woman's pregnancy precludes her from performing her job (i.e., her absence from work is medically necessary because she is disabled by pregnancy), she is entitled to FMLA leave and PDL, but no CFRA leave. When the child is born, the woman may choose to remain on Pregnancy Leave until the disability ends and then begin CFRA leave to bond with her newborn.

The distinction between the FMLA and the CFRA does not increase the maximum amount of time a woman may be out of work due to pregnancy. The maximum amount of leave is four months (for PDL/FMLA), plus 12 weeks for CFRA/FMLA leave to care for a newborn.

Military Family Leave (MFL)

On 1/28/08, President Bush signed into law the National Defense Authorization Act for FY 2008 (NDAA), Public Law 110-181. Section 585(a) of the NDAA amended the FMLA to provide eligible employees working for covered employers two important new leave rights related to military service:

1. **New Qualifying Reason for Leave.** Eligible employees are entitled up to 12 weeks of leave for "any qualifying exigency" because a spouse, son, daughter, or parent of the employee is on active duty, or has been notified of an impending call to active duty status, in support of a contingency operation. Until "any qualifying exigency" is fully defined, employers are encouraged to provide this type of leave to qualifying employees.
2. **New Leave Entitlement.** An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to a combined total of 26 weeks of FMLA leave in a single 12-month period to care for the service member. This provision became effective immediately upon enactment. Additional FMLA and Military Family Leave information is available on <https://www.dol.gov/whd/fmla/>.

Important Notices

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 626-580-2040

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, visit calpers.ca.gov.

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

You do not need prior authorization from the plan or any other person (including a primary care provider) 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, visit calpers.ca.gov.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Anthem Blue Cross, Blue Shield, Health Net, Kaiser and United Healthcare. 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.

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 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.

Important Notices (continued)

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified 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).

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 each dependent’s relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration’s written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

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

Important Notices (continued)

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. (See Notice and Election Procedures.)

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

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

Important Notices (continued)

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

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

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

IF YOU HAVE QUESTIONS

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

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

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.

Important Notices (continued)

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

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

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

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

For information about Special Enrollment Rights, please contact:

Human Resources/Risk Management Director
John Nguyen
626-580-2040

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 El Monte 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.**

Important Notices (continued)

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

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

If you do decide to join a Medicare drug plan and drop your current City of El Monte 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 El Monte 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 El Monte changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

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

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

REMEMBER

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

Date: September 21,2020
Name of Entity / Sender: City of El Monte
Contact: John Nguyen, Director
Address: 11333 Valley Boulevard
El Monte, CA 91731
Phone: 626-580-2040

Important Notices (continued)

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

City of El Monte 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/Risk Management at 626-580-2040.

Important Notices (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through Covered California will begin October 15, 2020, and is anticipated to 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 9.83% (for 2021) 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.

3. Employer name City of El Monte	4. Employer Identification Number (EIN)	
5. Employer address 11333 Valley Boulevard	6. Employer phone number 626-580-2040	
7. City El Monte	8. State CA	9. ZIP code 91731
10. Who can we contact about employee health coverage at this job? John Nguyen, Director of Human Resources/Risk Management		
11. Phone number (if different from above)	12. Email address humanresources@elmonteca.gov	

Important Notices (continued)

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 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
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
Phone: 916.440.5676

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
Health Insurance Buy-In Program (HIBI):
<https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program>
HIBI Customer Service: 855.692.6442

FLORIDA – Medicaid
Website:
<http://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hip/index.html>
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: <https://www.in.gov/medicaid/>
Phone: 800.457.4584

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: KIHIPPP.PROGRAM@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 or www.ldh.la.gov/lahipp
Phone: 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)

Important Notices (continued)

MAINE – Medicaid

Enrollment Website:

<https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 800.442.6003 | TTY: Maine relay 711

Private Health Insurance Premium Webpage:

<https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 800.977.6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website:

<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/other-insurance.jsp>

Phone: 800.657.3739

MISSOURI – Medicaid

Website:

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

Phone: 573.751.2005

MONTANA – Medicaid

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

Phone: 800.694.3084

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://dhcftp.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/City of El Montes/medicaid/>

Medicaid Phone: 609.631.2392

CHIP Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 800.701.0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/

Phone: 800.541.2831

NORTH CAROLINA – Medicaid

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

Phone: 919.855.4100

NORTH DAKOTA – Medicaid

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

Phone: 844.854.4825

OKLAHOMA – Medicaid and CHIP

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

Phone: 888.365.3742

OREGON – Medicaid

Websites: <http://healthcare.oregon.gov/Pages/index.aspx>

<http://www.oregonhealthcare.gov/index-es.html>

Phone: 800.699.9075

PENNSYLVANIA – Medicaid

Website:

<https://www.dhs.pa.gov/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/badgercareplus/p-10095.htm>

Phone: 800.362.3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>

Phone: 800.251.1269

To see if any other states have added a premium assistance program since July 31, 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

866.444.EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

877.267.2323, Menu Option 4, Ext. 61565

