2015 RETIREES BENEFITS GUIDE

glendale california

RETIREES

BENEFITS GUIDE

2015




what's inside

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 41 for more details.

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

introduction

Annual Open Enrollment

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

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

Important Dates

As a City of Glendale retiree, you may use this open enrollment period **(April 20, 2015 through May 11, 2015)** as an opportunity to make changes to your current medical and dental (if applicable) and vision insurance elections.

What's New for 2015

- **Medicare Age Retirees – Post 65:** Futuris Care / Medicare Exchange has been added as an alternate option to the City's Retirement Medical Programs.
- **Non-Medicare Age Retirees:** Online enrollment is available. From the internet, visit www.benefitbridge.com/glendale to complete the registration process.

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

Need Help with the Site?

Keenan & Associates can help. Contact the Help Desk at benefitbridge@keenan.com, or call 800.814.1862, Monday through Friday, 8:00 AM to 5:00 PM.

What To Do Now

Read this Open Enrollment Guide carefully to understand how your benefits package works. Review the materials enclosed in your Open Enrollment package, including the Benefit Verification Report. **If you want to keep the same coverage and dependents as shown on your Benefit Verification Report, you do not need to enroll or make any changes.**

Making Changes to Your Benefits

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

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

IRS Guidelines

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

- You marry, divorce, become legally separated or your marriage is annulled
- You establish or terminate a Domestic Partnership

introduction (continued)

- You gain a dependent through birth or adoption
- Your dependent dies
- Your dependent no longer meets the eligibility requirement (i.e., over age)
- You or your spouse has a change in employment status that results in gaining or losing eligibility for benefits coverage

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

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

*** Removing Dependents**

The effective date used when you remove a dependent will be the first of the month following the date of notification to the City. In addition, once you remove a dependent of the plan, they cannot be eligible to for re-enrollment.

eligibility

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

Employee Eligibility

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

Dependent Eligibility

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

- Your legal spouse or Domestic Partnership
- Your dependent children who are under age 26
- Provided dependents have not previously been a dependent during the employee's retirement

Important Notes About Dependent Eligibility

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

Over-Age Dependents

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

health plan options

Plans Available for Retirees Living in California

Non-Medicare Participants

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

Medicare Participants

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

Plans Available for Retirees Living Out-of-State

Non-Medicare Participants

- Blue Card Network PPO 80 / 60 Plan

Medicare Participants

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

health plan options (continued)

Futuris Care / Medicare Exchange Powered by CONEXIS Retiree Services

Futuris Care is a Medicare Exchange serviced by CONEXIS Retiree Services (CRS). Medicare Exchanges have been made available to Medicare eligible retirees since 2008. It is a way of shopping and comparing the three types of individual Medicare plans in your area. These types of plans include Medicare Advantage, Medicare supplement (Medigap), and Part D prescription drug plans. Your choice when reviewing the various types of plans is to select either a Medicare Advantage plan **OR** a Medigap **AND** Part D prescription drug plan.

Medicare Advantage plans coordinate with Medicare Parts A and B and are structured like a typical HMO. You will have in and out of network benefits that include doctor copays / coinsurance and will cost anywhere from $0 to $200 depending on the plan design and zip code. Your pharmacy benefits are also covered in a Medicare Advantage plan. A Medigap plan supplements Medicare, therefore, is accepted anywhere Medicare is accepted. There are 10 different plan designs that are designated by letter. The Plan F has the richest benefits. All Medicare covered benefits are also covered by the Plan F at 100%, therefore, once you pay your premium you will have no additional charges. Medigap plans do not include pharmacy benefits. You will need to purchase a separate prescription drug plan. The Part D prescription drug plans cover your pharmacy needs only. You will want to have your prescriptions in hand when reviewing these plans to see how they are covered on the different Part D plans.

Your current group plan satisfies Medicare's requirement to be enrolled in a prescription drug plan. When you enroll in a Medicare Advantage plan that has a prescription drug benefit or a stand alone Part D plan you may be asked for a letter of creditable coverage. The City will provide you with this letter stating that your current group plan meets Medicare's requirements. You should follow the instructions in the letter you receive from the carrier you selected to verify you had creditable coverage. This may include forwarding a copy of the City's letter to your carrier.

As part of this new program for the City of Glendale retirees, CONEXIS Retiree Services Benefits Advisors, who are licensed sales agents, will be calling you to review Medicare plans available to you. The Benefit Advisor will help you select and enroll in the Medicare plans mentioned above based on your individual needs. These are individual plans are specific to the county where you live, but may be portable depending on your selection. Your Benefits Advisor will help with all these details. Although you may purchase any one of the plans your Benefits Advisor will suggest on your own, the added service of having one individual review all available carriers at one time is invaluable.

Your CONEXIS Retiree Services Benefit Advisor can answer any questions you have during your call. You may call them in advance of your appointment at 888.616.7130. If you would like to review information prior to your call or if you would prefer to use their online tools, visit www.joppel.com/futuriscare.

how health plans work

Preferred Provider Organization (PPO) Plans

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

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

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

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

  Mail Order Prescription
  Generic: $10 (60-day supply)
  Brand: $20 (60-day supply)

- **Coordinating Benefits with Medicare.** Anthem Blue Cross will not provide benefits under this plan that duplicate any benefits to which you would be entitled under Medicare. This exclusion applies to all parts of Medicare in which you can enroll without paying an additional premium. If you are required to pay an additional premium for any part of Medicare, this exclusion will apply to that part of Medicare only if you are enrolled in that part.
- If you are entitled to Medicare, your Medicare coverage will not affect the services covered under this plan except as follows:
  - Medicare must provide benefits first to any services covered both by Medicare and under this plan.
  - For services you receive that are covered both by Medicare and under this plan, coverage under this plan will apply only to Medicare deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.

how health plans work (continued)

  - For any given claim, the combination of benefits provided by Medicare and the benefits provided under this plan will not exceed covered expenses for the covered services.

- Anthem Blue Cross will apply any charges paid by Medicare for services covered under this plan toward your plan deductible.

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

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

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

  Mail Order Prescription
  Generic: $10 (60-day supply)
  Brand: $20 (60-day supply)

how health plans work (continued)

Fee-for-Service – Medicare

- When you see a provider, simply present your ID card at your appointment. Your provider files the paperwork for your claim and you receive a bill in the mail for your deductible and/or coinsurance amount, usually 20% of the cost for most in-network covered services and the excess amount. In some instances, the provider might require payment up-front.
- Out-of-Network. After you incur $10,000 in covered expenses during a calendar year, you will no longer pay copays for the remainder of the year. You will, however, remain responsible for the deductibles, for costs in excess of the covered expense, and for non-covered expenses.
- When medication is prescribed, you must fill the prescription with a contracted retail pharmacy. You will pay the following:

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

  Mail Order Prescription
  Generic: $10 (60-day supply)
  Brand: $20 (60-day supply)

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

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

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

HMO Plans

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

Anthem CaliforniaCare and Kaiser Permanente – Non-Medicare

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

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

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

Kaiser Permanente Deductible HMO

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

Anthem Blue Cross Senior Secure and Kaiser Senior Advantage – Medicare

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

  Anthem Blue Cross Senior Secure
  $7 (30-day supply)

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

health plan decision guidelines

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

How Do I Compare Health Plans?

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

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

Things to Consider

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

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

california ppo plans

Non-Medicare and Medicare

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

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

* Pre-authorization required for facility-based care.

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

california ppo plans (continued)

Non-Medicare and Medicare

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

* Pre-authorization required for facility-based care.

Hospital Quality Comparison

If you are interested in comparing hospitals in your area, visit www.ucomparehealthcare.com.

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

california hmo plans

Non-Medicare

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

* Pre-authorization required for facility-based care

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

california hmo plans (continued)

Non-Medicare

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

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

california hmo plans

Medicare

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

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

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

out-of-state plans

Non-Medicare and Medicare

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

PPO 80 / 60 Plans: For Medicare participants, see "Coordination of Benefits" on page 26 of this Guide.

Summary of Services	Anthem Blue Cross Blue Card Network 80 / 60 Plan Non-Medicare		Anthem Blue Cross Fee-For-Service 80 Plan Medicare
	In-Network Benefits	Out-of-Network Benefits	Benefit
Maximum Lifetime Benefit	Unlimited		Unlimited
Annual Deductible			
• Member	$200	$400	$200
• Family	$400	$800	$400
Annual Out-of-Pocket Maximum	$2,000	$4,000	After an insured incurs $10,000 in covered expenses during a calendar year, the insured no longer pays copays for the remainder of the year.
	PPO Member Copay	Non-PPO Member Copay	Member Copay
Preventive Services			
• Office Visits	$20 / deductible waived	40%	20%
• Visit to a Specialist	$20 / deductible waived	40%	20%
• Annual Physicals	No copay	Not covered	20%
• Mammograms	No copay	40%	No copay
• Vision Exams and Frames	Not covered	Not covered	Not covered
• X-Ray and Laboratory	20%	20%	20%
• Chiropractic Services	20%	40% (limit $25 / visit)	20%
• Dental Coverage	Not covered	Not covered	Not covered
Emergency Service			
• Hospital Emergency Room *(deductible waived if admitted)*	$100 deductible + 20%	$100 deductible + 20%	20%
• Hospital Inpatient Services	20%	20 % (1st 48 hours; 40% after 48 hours)	20%
• Ambulance	20%	20%	20%

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

out-of-state plans (continued)

Non-Medicare and Medicare

Summary of Services	Anthem Blue Cross Blue Card Network 80 / 60 Plan Non-Medicare		Anthem Blue Cross Fee-For-Service 80 Plan Medicare
	In-Network Benefits	Out-of-Network Benefits	Benefit
	PPO Member Copay	Non-PPO Member Copay	Member Copay
Inpatient Hospital *			
• Inpatient Surgery	20%	40%	20%
• Mental or Nervous Disorders	20%	40%	20%
• Acute Alcoholism or Drug Dependence	20%	40%	20%
Outpatient Hospital			
• Outpatient Surgery	20%	40%	20%
• Mental or Nervous Disorders	20%	40%	20%
• Acute Alcoholism or Drug Dependence	20%	40%	20%
Prescription			
• Generic	$10 (30-day supply)		$10 (30-day supply)
• Brand	$20 (30-day supply)		$20 (30-day supply)
• Mail Order Prescription Drugs	$10 / $20 (60-day supply)		$20 / $40 (90-day supply)
• Limits in a Calendar Year	None		None

* Pre-authorization required for facility-based care.

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

futuris comparison

Conexis Exchange Medicare Supplement and Part D Options
Los Angeles County

Summary of Services	Major Carrier		
	Supplement Plan F		Mid-Range Premium Plan
	$157.51 (male age 65)	$215.68 (male age 73)	$51.10
	Medicare Supplement In-Network Benefits		Part D (PDP) In-Network
Maximum Lifetime Benefit	Unlimited		N/A
Annual Deductible			
• Member / Family	N/A		N/A
Annual Out-of-Pocket Maximum	N/A		N/A
Preventive Services			
• PCP Office Visit	0% coinsurance		N/A
• Specialist Office Visit	0% coinsurance		N/A
• Annual Physical	0% coinsurance		N/A
• Mammograms	0% coinsurance		N/A
• X-Ray and Lab Services	0% coinsurance		N/A
• Chiropractic	0% coinsurance		N/A
• Vision Exams and Frames	0% coinsurance (Medicare Covered)		N/A
• Hearing Covered	0% coinsurance (Medicare Covered)		N/A
• Dental Coverage	Optional		N/A
Emergency Service			
• Emergency Room	0% coinsurance		N/A
• Hospital Inpatient Services	0% coinsurance		N/A
• Ambulance	0% coinsurance		N/A
Inpatient Hospital Services			
• Inpatient Surgery	0% coinsurance		N/A
• Mental Healthcare	0% coinsurance		N/A
• Substance Abuse Counseling	0% coinsurance		N/A
Outpatient Hospital			
• Outpatient Surgery	0% coinsurance		N/A
• Mental Healthcare	0% coinsurance		N/A
• Substance Abuse Counseling	0% coinsurance		N/A

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

Conexis Exchange Medicare Supplement and Part D Options (continued)
Los Angeles County

Summary of Services	Major Carrier		
	Supplement Plan F		Mid-Range Premium Plan
	$157.51 (male age 65)	$215.68 (male age 73)	$51.10
	Medicare Supplement In-Network Benefits		Part D (PDP) In-Network
Prescription Drugs			
• Retail Pharmacy *(30-day Supply)*			
– Initial Coverage Limit	N/A		N/A
– Preferred Generic	N/A		$2 copay
– Non-Preferred Generic	N/A		$5 copay
– Preferred Brand	N/A		$40 copay
– Non-Preferred Brand	N/A		$85 copay
– Injectible Drugs	N/A		N/A
– Specialty	N/A		33% coinsurance
• Mail Order *(90-day Supply)*			
– Preferred Generic	N/A		$0 copay
– Non-Preferred Generic	N/A		$5 copay
– Preferred Brand	N/A		$115 copay
– Non-Preferred Brand	N/A		$250 copay
– Injectible Drugs	N/A		N/A
– Specialty	N/A		33% coinsurance
– Annual Limit	N/A		N/A

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

Conexis Exchange MAPD HMO Offerings
Los Angeles County

Summary of Services	Major Carrier Medicare Advantage w/Prescription Drugs	
	$0.00	$0.00
	Medicare Advantage HMO In-Network Benefits	Medicare Advantage HMO In-Network Benefits
Maximum Lifetime Benefit	Unlimited	Unlimited
Annual Deductible	N/A	N/A
Annual Out-of-Pocket Maximum	$2,800	$3,000
Preventive Services		
• PCP Office Visit	$0 copay	$0 copay
• Specialist Office Visit	$0 copay	$0 copay
• Annual Physical	$0 copay	$0 copay
• Mammograms	$0 copay (one/year)	$0 copay (one/year)
• X-Ray and Lab Services	$0 copay	$0 copay
• Chiropractic	$0 copay	$0 copay
• Vision Exams and Frames	$20 copay (one routine/year) $75 allowance (once/year)	$0 copay (one routine/year)
• Hearing Covered	$0 copay (routine exam one/year)	$0 copay exam (routine one/year) $500 hearing aid allowance (every two years)
• Dental Coverage	Optional	Optional
Emergency Service		
• Emergency Room	$65 copay (waived if admitted)	$65 copay (waived if admitted)
• Hospital Inpatient Services	$0 copay	$0 copay
• Ambulance	$200/trip	$200/trip
Inpatient Hospital Services		
• Inpatient Surgery	$0 copay	$0 copay
• Mental Healthcare	$900 copay/admit	$0 copay
• Substance Abuse Counseling	$900 copay/admit	$0 copay
Outpatient Hospital		
• Outpatient Surgery	$0 copay (ambulatory surgical) $100 copay (outpatient hospital)	$0 to $25 copay (ambulatory) $0 to $75 copay (outpatient hospital)
• Mental Healthcare	$30 copay (individual or group)	$10 copay (individual or group)
• Substance Abuse Counseling	$30 copay (individual or group)	$10 copay (individual or group)

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

Conexis Exchange MAPD HMO Offerings (continued)
Los Angeles County

Summary of Services	Major Carrier Medicare Advantage w/Prescription Drugs	
	$0.00	$0.00
	Medicare Advantage HMO In-Network Benefits	Medicare Advantage HMO In-Network Benefits
Prescription Drugs		
• Retail Pharmacy *(30-day Supply)*		
– Initial Coverage Limit	$2,850	$2,850
– Preferred Generic	$0 copay	$3 copay
– Non-Preferred Generic	$5 copay	$10 copay
– Preferred Brand	$45 copay	$40 copay
– Non-Preferred Brand	$85 copay	$85 copay
– Injectible Drugs	25% coinsurance	N/A
– Specialty	33% coinsurance	33% coinsurance
• Mail Order *(90-day Supply)*		
– Preferred Generic	$0 copay	$9 copay
– Non-Preferred Generic	$10 copay	$20 copay
– Preferred Brand	$90 copay	$80 copay
– Non-Preferred Brand	$170 copay	$170 copay
– Injectible Drugs	25% coinsurance	N/A
– Specialty	33% coinsurance	33% coinsurance
– Annual Limit	N/A	N/A

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

Conexis Exchange Medicare Supplement and Part D Options
Orange County

Summary of Services	Major Carrier		
	Supplement Plan F		Mid-Range Premium Plan
	$168.00 (male age 65)	$243.32 (male age 73)	$51.10
	Medicare Supplement In-Network Benefits		Part D (PDP) In-Network
Maximum Lifetime Benefit	Unlimited		N/A
Annual Deductible			
• Member / Family	N/A		N/A
Annual Out-of-Pocket Maximum	N/A		N/A
Preventive Services			
• PCP Office Visit	0% coinsurance		N/A
• Specialist Office Visit	0% coinsurance		N/A
• Annual Physical	0% coinsurance		N/A
• Mammograms	0% coinsurance		N/A
• X-Ray and Lab Services	0% coinsurance		N/A
• Chiropractic	0% coinsurance		N/A
• Vision Exams and Frames	0% coinsurance (Medicare Covered)		N/A
• Hearing Covered	0% coinsurance (Medicare Covered)		N/A
• Dental Coverage	Optional		N/A
Emergency Service			
• Emergency Room	0% coinsurance		N/A
• Hospital Inpatient Services	0% coinsurance		N/A
• Ambulance	0% coinsurance		N/A
Inpatient Hospital Services			
• Inpatient Surgery	0% coinsurance		N/A
• Mental Healthcare	0% coinsurance		N/A
• Substance Abuse Counseling	0% coinsurance		N/A
Outpatient Hospital			
• Outpatient Surgery	0% coinsurance		N/A
• Mental Healthcare	0% coinsurance		N/A
• Substance Abuse Counseling	0% coinsurance		N/A

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

Conexis Exchange Medicare Supplement and Part D Options (continued)
Orange County

Summary of Services	Major Carrier		
	Supplement Plan F		Mid-Range Premium Plan
	$168.00 (male age 65)	$243.32 (male age 73)	$51.10
	Medicare Supplement In-Network Benefits		Part D (PDP) In-Network
Prescription Drugs			
• Retail Pharmacy *(30-day Supply)*			
– Initial Coverage Limit	N/A		N/A
– Preferred Generic	N/A		$2 copay
– Non-Preferred Generic	N/A		$5 copay
– Preferred Brand	N/A		$40 copay
– Non-Preferred Brand	N/A		$85 copay
– Injectible Drugs	N/A		N/A
– Specialty	N/A		33% coinsurance
• Mail Order *(90-day Supply)*			
– Preferred Generic	N/A		$0 copay
– Non-Preferred Generic	N/A		$5 copay
– Preferred Brand	N/A		$115 copay
– Non-Preferred Brand	N/A		$250 copay
– Injectible Drugs	N/A		N/A
– Specialty	N/A		33% coinsurance
– Annual Limit	N/A		N/A

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

Conexis Exchange MAPD HMO Offerings
Orange County

Summary of Services	Major Carrier Medicare Advantage w/Prescription Drugs	
	$0.00	$0.00
	Medicare Advantage HMO In-Network Benefits	Medicare Advantage HMO In-Network Benefits
Maximum Lifetime Benefit	Unlimited	Unlimited
Annual Deductible	N/A	N/A
Annual Out-of-Pocket Maximum	$2,000	$4,900
Preventive Services		
• PCP Office Visit	$0 copay	$5 copay
• Specialist Office Visit	$0 copay	$10 copay
• Annual Physical	$0 copay	$0 copay
• Mammograms	$0 copay (one/year)	$0 copay (one/year)
• X-Ray and Lab Services	$0 copay Labs $10 copay X-Ray	$13 copay Labs $0 copay X-Ray
• Chiropractic	$20 copay	$10 copay
• Vision Exams and Frames	$0 copay (one routine/year)	$10 copay (one routine exam/year)
• Hearing Covered	$0 copay (routine exam one/year)	$5 copay exam (routine one/year) $450 hearing aid allowance (every two years)
• Dental Coverage	Optional	Optional
Emergency Service		
• Emergency Room	$65 copay (waived if admitted)	$65 copay (waived if admitted)
• Hospital Inpatient Services	$0 copay	$0 copay
• Ambulance	$350/trip	$250/trip
Inpatient Hospital Services		
• Inpatient Surgery	$0 copay	Days 1-5: $150 copay/day
• Mental Healthcare	$1,480 copay/admit	Days 1-5: $150 copay/day
• Substance Abuse Counseling	$1,480 copay/admit	Days 1-5: $150 copay/day
Outpatient Hospital		
• Outpatient Surgery	$0 copay (ambulatory surgical) $0 copay (outpatient hospital)	$125 copay (ambulatory) $0 to $125 copay (outpatient hospital)
• Mental Healthcare	$40 copay (individual or group)	$30 copay (individual or group)
• Substance Abuse Counseling	$40 copay (individual or group)	$30 copay (individual or group)

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

Conexis Exchange MAPD HMO Offerings (continued)
Orange County

Summary of Services	Major Carrier Medicare Advantage w/Prescription Drugs	
	$0.00	$0.00
	Medicare Advantage HMO In-Network Benefits	Medicare Advantage HMO In-Network Benefits
Prescription Drugs		
• Retail Pharmacy *(30-day Supply)*		
– Initial Coverage Limit	$2,850	$2,850
– Preferred Generic	$5 copay	$4 copay
– Non-Preferred Generic	N/A	$8 copay
– Preferred Brand	25% coinsurance	$45 copay
– Non-Preferred Brand	50% coinsurance	$95 copay
– Injectible Drugs	N/A	N/A
– Specialty	33% coinsurance	33% coinsurance
• Mail Order *(90-day Supply)*		
– Preferred Generic	$15 copay	$8 copay
– Non-Preferred Generic	N/A	$16 copay
– Preferred Brand	25% coinsurance	$125 copay
– Non-Preferred Brand	50% coinsurance	$275 copay
– Injectible Drugs	N/A	N/A
– Specialty	33% coinsurance	33% coinsurance
– Annual Limit	N/A	N/A

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

coordination of benefits

Anthem Blue Cross 80 / 60 Plan

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

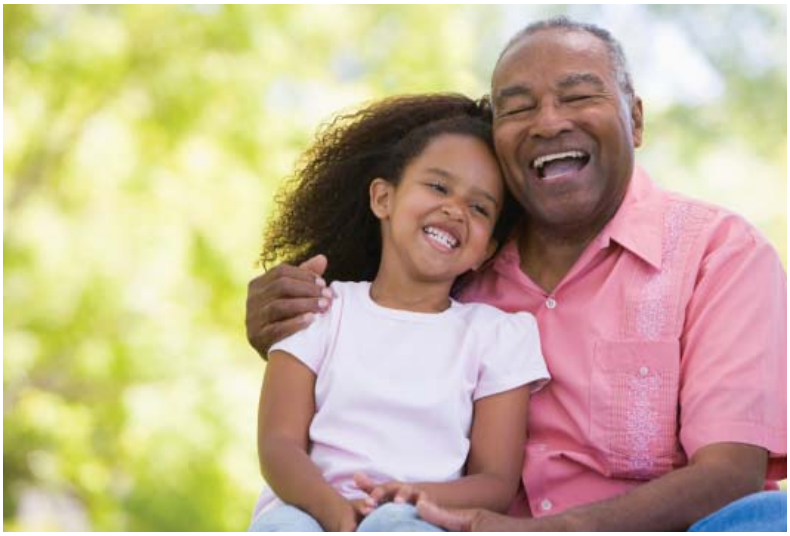
Coordination of Benefits with Medicare

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

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

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

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



dental

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

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

1. High Option PPO
2. Buy-Up PPO
3. MDC-G90 DMO

High Option PPO & Buy-Up PPO

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

MDC-G90 DMO

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

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

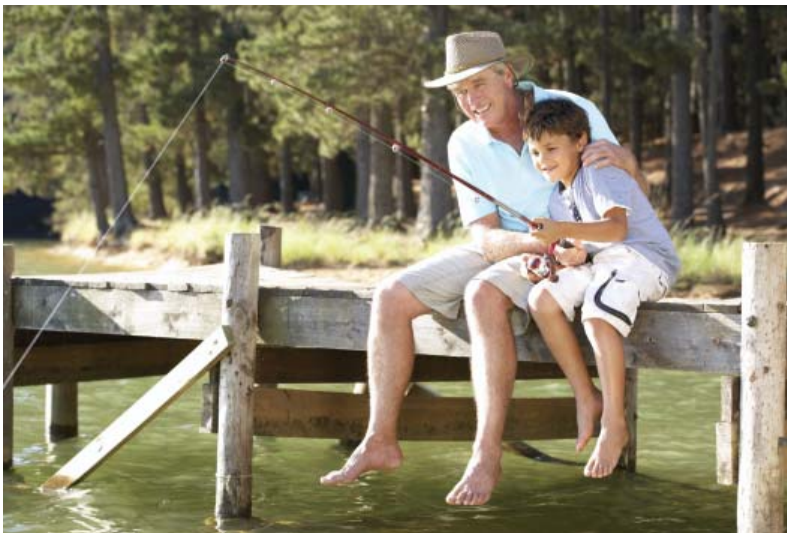
dental (continued)

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

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

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

vision



We're so glad you're a member. Your eyes are amazing, and we'll treat them amazingly well. We're committed to keeping you and your eyes healthy year after year.

Using Your VSP Benefit is Easy

- Find the right eyecare provider for you. Choose a VSP doctor or any other provider. To find a VSP doctor, visit vsp.com or call 800.877.7195.
- Review your benefit information. Visit vsp.com to review your plan coverage before your appointment.
- At your appointment tell them you have VSP. There's no ID card necessary.

That's it! We'll handle the rest; there are no claim forms to complete when you see your VSP doctor.

You'll Get More than The Basics and at a Great Price

A VSP doctor provides personalized care that focuses on keeping you and your eyes healthy year after year. Our WellVision Exam® is more than a quick eye check. Our doctors take their time and look for eye problems and signs of other health conditions too. Plus, when you see a VSP doctor, you'll get the most out of your benefit and have lower out-of-pocket costs.

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

Thanks for letting us help you see well, stay healthy, and get the most out of life. You'll be 100% happy when you see a VSP doctor or we'll make it right.

vision (continued)

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

Vision Service Plan (VSP) Eligibility

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

Vision Plan At-a-Glance

Plan Benefits	Frequency	Copay	Coverage
In-Network VSP Provider			
Exams	Every 12 months	$10 for exam and / or eyewear	100%
Lenses			
• Single, Lined Bifocal, Lined Trifocal	Every 12 months	$10 for exam and / or eyewear	100% In addition, Polycarbonate lenses for dependent children are fully covered.
Frames	Every 12 months	$10 for exam and / or eyewear	You have a $150 allowance for any frame. Plus you get 20% off any amount over your allowance. **Additional Information:** If you have had laser correction surgery, you can also use your VSP frame allowance toward the cost of non-prescription sunglasses obtained from any VSP doctor. Proof of surgery will be required from a VSP doctor for the allowance. 20% off additional glasses and sunglasses from any VSP doctor within 12 months of your eye exam.
Contacts *(in lieu of glasses)*	Every 12 months	None	You get a $130 allowance for contacts and contact lens exam (fitting and evaluation)
Non-VSP Provider	At a non-VSP provider, your benefit is substantially reduced. If you use the services of a non-preferred provider, you must submit the itemized bill to VSP for claims payment within 180 days from date of services. Contact VSP customer service for detailed information at 800.877.7195		

VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

This information doesn't guarantee your eligibility or coverage. Your VSP doctor will contact VSP to check your eligibility.

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

health and wellness

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

Tips for Using Your Benefits Wisely

Use Preventive Care Benefits

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

Visit an Urgent Care Facility Instead of the ER

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

Choose Generic Drugs

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

Use Anthem's Online Tools

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

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

health and wellness (continued)

Use Kaiser's Online Tools

You may be able to save yourself an office visit! Visit www.kp.org to get answers to your health questions from your own doctor, or take a self-guided health living course. Kaiser website offers there members in the Health and Wellness Tool Kits:

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

Patient Advocacy Tools

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

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

retired city guidelines

Medical Guidelines and Provisions

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

Dental Guidelines and Provisions

- Dental coverage maybe continued with the City if this benefit was provided within the employee's respective MOU or benefit ordinance provision at the time of retirement.
- Retired employees may add new dependents after the retirement (consistent with the plan terms and contracts) provided they have not previously been a dependent during the employees' retirement.

retired city guidelines (continued)

- The spouse of a deceased retired City employee may remain on the insurance plan after the death of the retired employee subject to plan restrictions and requirements.
- Retired City employees or dependents who separate from the City's Retirement Medical Program for any reason, including but not limited to non-payment of premium, relinquish their right to any future participation and shall not be eligible to rejoin the plan at a later date.

Vision Guidelines and Provisions

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

Life Guidelines and Provisions

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

Important

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

retiree billing services

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

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

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

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

PayFlex Systems USA
10802 Farnam Drive, Suite 100
Omaha, NE 68154

If you have any questions, please contact PayFlex (800.284.4885) for customer service.

Important

Notify City of Glendale when terminating coverage.

City of Glendale
Benefits
613 E. Broadway, Room 100
Glendale, CA 91206
818.548.2160
benefits@glendaleca.gov

health care reform update

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

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

Meeting the Individual Mandate

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

Government-Sponsored Programs

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

Health Insurance Marketplace or Individual Market

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

If you are eligible for medical coverage from the City, while you are welcome to apply for coverage through the marketplaces, you will be required to pay 100% of the cost. You won't be eligible for a subsidy. That's because the City of Glendale provides you with coverage options that exceed the government's requirements for affordable and comprehensive benefits.

Other Health Coverage

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

No Coverage

You also have the option to not have any health insurance in 2015. However, if you choose to be uninsured in 2015 you will pay a tax penalty when you file your 2015 taxes (to determine your potential tax penalty, go to www.HealthCare.gov).

legal notices

Statement of Belief – Grandfather Status

The City of Glendale believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator:

Human Resources, Benefits
613 E. Broadway, Room 100
Glendale, CA 91206
818.548.2160

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866.444.3272 or visit www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Newborns and Mothers Health Protection Act (NMHPA)

A health plan which provides benefits for pregnancy delivery generally may not restrict benefits for a covered pregnancy Hospital stay (for delivery) for a mother and her newborn 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)

Do you know that 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, prosthetics, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 818.548.2160 for more information.

Grievance / Appeals

You have a right to two levels of appeal with our carriers, and a right to a response within a reasonable amount of time. However, also know that if a claim is not submitted within a reasonable time, the carriers have a right to deny that claim. The California Department of Managed Health Care (DMHC) is responsible for regulating health care plans. If you have a grievance against your health plan, you should first telephone your health plan and use your plan's appeal process before contacting the DMHC. Please review each contract for specific procedures on how to submit an appeal to a claim. This does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency or that has not been satisfactorily resolved by your health plan, or that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for Independent Medical Review for an impartial review of medical decisions made by a health plan related to medical necessity, coverage decisions for treatments that are experimental in nature, and payment disputes for emergency or urgent medical services. The DMHC can be reached at 888.HMO.2219 (TDD 877.688.9891) or www.hmohelp.ca.gov.

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.

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

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 cover must pay for COBRA continuation coverage.

If you're an Employee, you'll 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're the spouse of an Employee, you'll become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to Human Resources, Benefits.

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 furnished by U.S. mail, registered or certified, postage prepaid and properly addressed to the Plan Administrator.

Each notice must include all of the following items: the Covered Employee's full name, address, phone number and Social Security number; the full name, address, phone number and Social Security number of each affected Dependent, as well as the Dependent's

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

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

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

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

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

OTHER OPTION BESIDES COBRA CONTINUATION COVERAGE

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

IF YOU HAVE QUESTIONS

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/

ebsa. (Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.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 later 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, or any termination of COBRA coverage based on the criteria stated in this subsection that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate. Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description for more information.

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 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).

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

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

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

If you decide to join a Medicare drug plan, your current City of Glendale coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current City of Glendale coverage, be aware that you and your Dependents may not 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 the City of Glendale and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. NOTE: You 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 the City of Glendale changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

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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:	April 2015
Name of Entity / Sender:	City of Glendale
Contact:	Human Resources, Benefits
Address:	613 E. Broadway, Room 100 Glendale, CA 91206
Phone:	818.548.2160

contact information

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

For Questions About ...	Phone	E-mail / Website
Benefits or Enrolling		
• Deisi Alvarez, Benefits Technician	818.548.2160	benefits@glendaleca.gov
City's Retirement Process		
• Teri Taylan, Benefits Manager	818.550.4403	ttaylan@glendaleca.gov
City's Retirement Billing		
• PayFlex	800.284.4885	www.healthhub.com
City's Deferred Compensation Plans and RHSP		
• Finance Department	818.548.2106	payroll@glendaleca.gov
Medical Plans		
• Anthem Blue Cross		
– PPO & HMO	800.288.2539	www.anthem.com/ca
– Senior Secure	800.225.2273	
• Anthem Rx	866.274.6825	www.anthem.com/ca
• Kaiser Permanente	800.464.4000	www.kp.org
• Conexis / Futuris Care	888.616.7130	www.joppel.com/futuriscare
Dental Plans		
• Guardian		
– PPO	800.541.7846	www.guardiananytime.com
– DMO	800.459.9401	www.guardiananytime.com
Pension Plans		
• CalPERS 655 N. Central Avenue, Suite 1400 Glendale, CA 91203	888.225.7377	www.calpers.ca.gov
• PAR-ARS	800.540.6369	www.parsinfo.com
Social Security and Medicare		
• Social Security	800.772.1213	www.ssa.gov

Keenan & Associates

Innovative Solutions. Enduring Principles.

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