Summary of Benefits

Open Enrollment 2018 – 2019

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If you (and/or your dependents) have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 23 for more details.

The information in this brochure is a general outline of the benefits offered under Client'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.

Dear El Monte Colleagues,

Today, we kick-off Open Enrollment for the 2019 Benefit Plan year. The health care and health insurance marketplace is in the midst of profound change, a process that will continue for the foreseeable future. The Affordable Care Act and the relentless climb in health care costs are forcing everyone — insurance carriers, medical providers, employers and employees — to adapt continuously. One change, going forward, the Human Resources/Risk Management Department has become more engaged in the City's health benefit choices.

As health care costs continue to rise across the country, we remain committed to providing our employees with a comprehensive and affordable health care plan.

Open Enrollment will take place September 10, 2018 to October 10, 2018 featuring a Benefits Fair on Wednesday, September 19, 2018. As you prepare to make important decisions about your benefit options for 2019, here are a few highlights:

- Our medical plans have experienced some cost differentials based on CalPERS pricing adjustments;
- We will remain with Cigna Dental for the upcoming plan year as we continue to review usage and benefit utilization amongst our enrolled population;
- We will remain with EyeMed Vision – featuring new benefit options including; Freedom Pass and new frames every twelve months opposed to every 24 months; and
- With the assistance of our broker, Keenan & Associates, we are pleased to introduce American Fidelity, our newest partner within the Benefits Plan; offering enhancements to our selection of Section 125 benefit options; including Flexible Spending Accounts and other ancillary benefit options.

Additionally, we continue to support ways for you to improve your health throughout Wellness Program initiatives.

I recognize and appreciate the importance of your own health and the health of your families. Open enrollment is the perfect time to review your benefit options and make important decisions for yourself and your covered dependents. In fact, American Fidelity will be on site the week of September 10th to meet with every employee for a personal one-on-one Benefit Counseling Session.

Lastly, please take time to carefully read the updates in this brochure and visit the Human Resources/Risk Management website [insert] to access benefits information. **Whether you're keeping your benefits from 2018 or making changes, or enrolling for the first time, we expect all employees to enroll to have benefits in 2019**.

If you have any questions, please contact a representative of the Human Resources/Risk Management Department.

Sincerely, Angela McCray
Human Resources/Risk Management Director City of El Monte

General Information

What is Open Enrollment?

This booklet is a summary of your benefits package for Benefit Year 2019. Take the time to review the information, so that you can make the best selections for you and your family. All information, including the amount of any benefit and employee eligibility for benefits, is subject to and governed by the terms and conditions of the applicable policy or plan documents. If any information provided in this guide differs from information provided by the policy or plan the terms of the plan will control.

Open Enrollment is September 10, 2018 to October 5, 2018.

This year's open enrollment period takes place from September 5 to October 5, 2018. All employees are required to complete an enrollment form available within the Human Resources/Risk Management Department.

Things to Consider during Participation:

As a current City of El Monte employee, if any of the following statements are true, then you most definitely need to participate in Open Enrollment:

- You have a change of address;
- You have not verified/updated your beneficiary information in two or more years;
- You currently cover a spouse or dependent under your health benefits (who is not eligible) and you want to continue their coverage in 2019;
- You want to enroll, change, or remove coverage for yourself and/or your eligible dependents for health or dental insurance;
- You want to enroll or change life insurance, accidental death & dismemberment, or voluntary benefit options for yourself and/or your eligible dependents;
- You want to enroll or re-enroll in a flexible spending account (FSA).

Each year during Open Enrollment, the City of El Monte employees and retirees have a chance to make important decisions that impact benefits for the upcoming plan period (2019). It is important to keep in mind that the choices you make cannot be reversed until the next Annual Open Enrollment period. After Open Enrollment ends, you cannot do any of the following with a qualifying event:

- Switch from one health plan to another;
- Switch from one dental/vision plan to another;
- Add yourself or additional dependents to health, dental/vision, life or FSA coverage;
- Cancel or alter your own and/or your dependents health or dental/vision plan coverage;
- Add or alter Flexible Spending Account contributions;
- Add, cancel or alter voluntary vision, dental, life services and/or critical illness.

Changes can be made for certain qualifying events, such as marriage, childbirth or adoption, loss of existing coverage for family members or retirement, and the result of a move. Changes must be made within 60 days of the qualifying event.

What's New for 2019

CalPERS announced the rates for medical premiums for the 2019 calendar year and there are some changes. The approved health care benefits package premium increases may change based upon specific elections, depending on your plan elections.

- Our medical plans have experienced some cost differentials based on CalPERS pricing adjustments;
- We will remain with Cigna Dental for the upcoming plan year as we continue to review usage and benefit utilization amongst our enrolled population;
- We will remain with EyeMed Vision – featuring new benefit options including; Freedom Pass and new frames every twelve months opposed to every 24 months; and
- With the assistance of our broker, Keenan & Associates, we are pleased to introduce American Fidelity, our newest partner within the Benefits Plan; offering enhancements to our selection of Section 125 benefit options; including Flexible Spending Accounts and other ancillary benefit options.

General Information (continued)

Employee Benefit Eligibility

Full-time employees or part-time employees with benefits are eligible for coverage under the benefit plans. If both you and your spouse work for the city, you may select coverage as an employed or dependent. However, dependents can only be enrolled under one parent.

Dependent Eligibility

- Legal Spouse / Domestic Partner
- Children up to age 26, including natural born, foster, stepchildren legally adopted, placed for adoption or children whom you are a legal guardian;
- Unmarried children beyond 26 who are incapable of self-sustaining employment because of a mental or physical disability incurred before age 19.

Domestic Partner Coverage

Health insurance coverage may be extended to an employee's domestic partner and child(ren) with completion of a notarized Domestic Partnership Affidavit and supporting documentation on file. Contact Human Resources to select or change domestic partner coverage and to discuss important tax considerations.

Special Enrollment Periods

You will not be considered a Late Enrollee if you qualify under a Special Enrollment Period as defined below. If one of these situation applies, you may enroll before the next annual enrollment period.

Loss of Other Health Care Coverage:

You or your dependents may qualify for a special enrollment period if:

- You did not enroll yourself or your dependent when you first became eligible or during any subsequent annual enrollments because, at that time:
  - You or your dependents were covered under other creditable coverage; and
  - You refused coverage, and stated in writing, at the time you refused coverage that the reason was that you or your dependents had other creditable coverage.
- You or your dependents are no longer eligible for other creditable coverage because of one of the following:
  - The end of your employment;
  - A reduction in hours of employment (for example, moving from a full-time to part-time position);
  - The ending of the other plan's coverage;
  - Death
  - Divorce or legal separation;
  - Employer contributions toward that coverage have ended;
  - COBRA coverage ends;
  - The employer's decision to stop offering the group health plan to the eligible class to which you belong;
  - Cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
  - With respect to coverage under Medicaid or similar Plan, you or your dependents no longer qualify for such coverage; or
  - You or your dependents have reached to lifetime maximum of another Plan for all benefits under that Plan.
  - Your or your dependents become eligible for premium assistance, with respect to coverage under the group health plan, under Medicaid.
- You will need to enroll yourself or a dependent for coverage within:
  - 30 days of when other creditable coverage ends;
  - Within 60 days of when coverage under Medicaid ends; or
  - Within 60 days of the date you or your dependents become eligible for Medicaid or premium assistance.

Evidence of termination of creditable coverage must be provided to HR Benefits. If you do not enroll during this time, you will need to wait until the next annual enrollment period.

General Information (continued)

New Dependents

You and your dependents may qualify for a special enrollment period if:

- You did not enroll when you were first eligible for coverage; and
- You later acquire a dependent, as defined under the plan, through marriage, birth, adoption or placement for adoption, and
- You elect coverage for yourself and your dependent within 30 days of acquiring the dependent.

Your spouse and child who meets the definition of a dependent under the plan my qualify for a special enrollment period if:

- You did not enroll them when they were first eligible; and
- You later elect coverage for them within 30 days of a court order requiring you to provide coverage.

You will need to report any new dependents by submitting a change form. The change must be completed within 30 days. If you do not report new dependents within 30 days of the change, you will need to make the changes during the next annual enrollment period.

If you Adopt a Child

Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 30 days of the placement;
- Proof of placement will need to be presented to Benefits before the dependent enrollment;
- Any coverage limitations for a pre-existing condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage;

When you Receive a Qualified Child Support Order

A Qualified Medical Child Support Order is a court order requiring a parent to provide health care coverage to one or more children. Your plan will provide coverage for a child who is covered under a (QMCSO), if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 30 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 30-day period.

If you do not request coverage for the child within the 30-day period, you will need to wait until the next annual enrollment period.

Under a CMCSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

When participating in Open Enrollment, please keep in mind that the choices you make will be permanent until the next Annual Open Enrollment period arrives, with changes effective January 1, 2019. For this reason, it is very important to spend time carefully reviewing Open Enrollment materials to make sure you select the plans that best meet your coverage and financial needs.

City of El Monte Wellness Week!

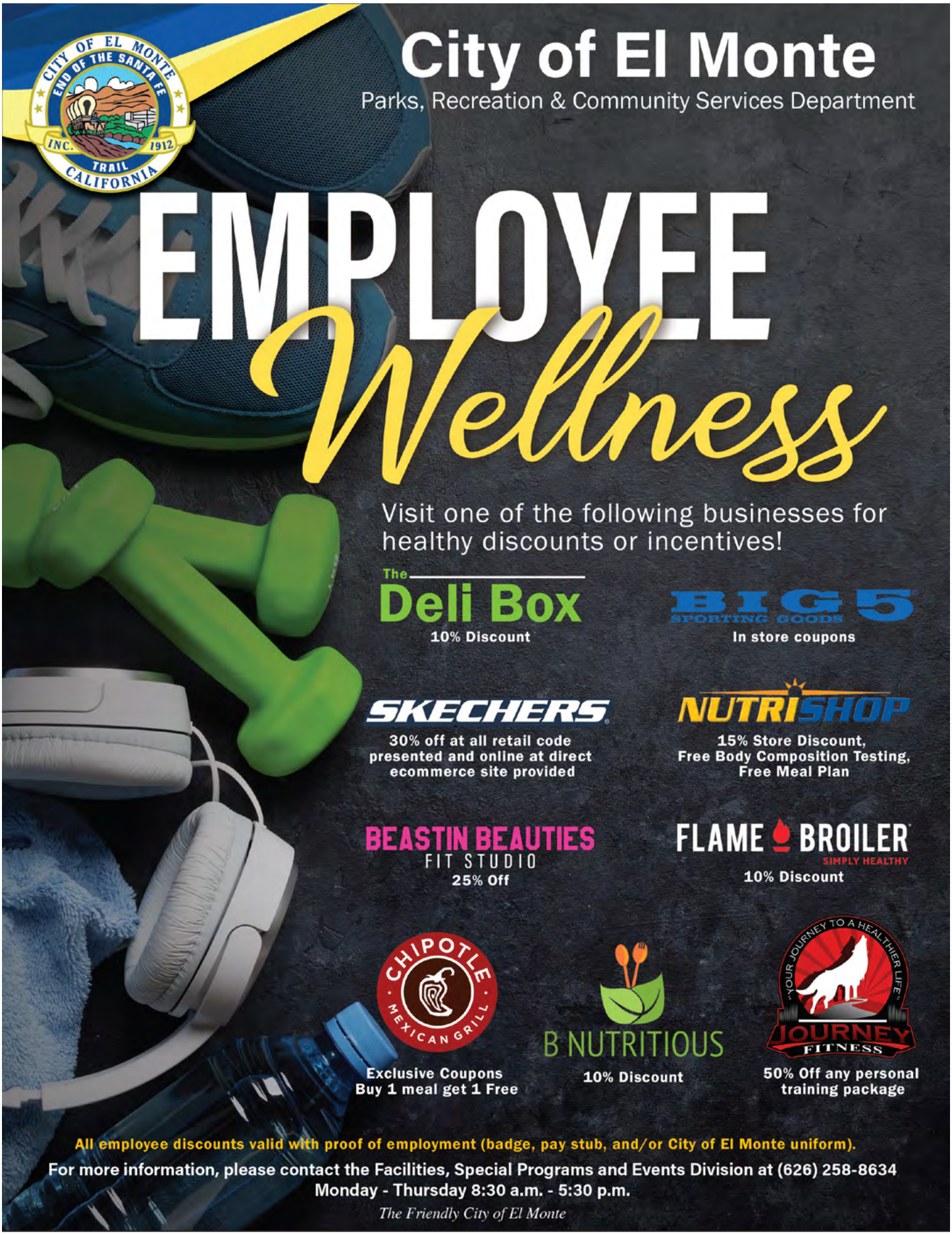
September 17-20, 2018

- The City of El Monte is hosting a week of wellness activities between *September 17 - 20, 2018.*
- Each day of the week employees are encouraged to participate in different wellness activities.
- Employees who participate in wellness activities will qualify for a prize drawing!
- Complete the Wellness Week survey.
- See below schedule for a list of wellness week activities!

Wellness Week Schedule		
Date	**Activity**	**Details**
Monday, September 17	Bring a healthy lunch to work	Employees are encouraged to **bring a healthy lunch to work.**
Tuesday, September 18	Take a 15 minute walk	Employees are encouraged to ***take a 15 minute walk.***
Wednesday, September 19 9:00 a.m. - 3:00 p.m.	Open Enrollment & Benefits Health Fair El Monte Community Center	Employees are encouraged to attend the annual health fair and complete a **biometric screening and My Life Check Health Assessment.**
Thursday, September 20 11:30 a.m.	Healthy Cooking Demonstration El Monte Community Center	Employees are encouraged to participate in a on-site **healthy cooking demonstration. (Limited to 30 employees)**

** Lap Swim and Aerobics are free all week!

Questions or to RSVP? Please contact Johana Coca (dcoca@elmonteca.gov)


City of El Monte
Parks, Recreation & Community Services Department
EMPLOYEE
Wellness
Visit one of the following businesses for healthy discounts or incentives!
The Deli Box
10% Discount
BIG 5 SPORTING GOODS
In store coupons
SKECHERS
30% off at all retail code presented and online at direct ecommerce site provided
NUTRISHOP
15% Store Discount, Free Body Composition Testing, Free Meal Plan
BEASTIN BEAUTIES
FIT STUDIO
25% Off
FLAME BROILER
SIMPLY HEALTHY
10% Discount
CHIPOTLE
MEXICAN GRILL
Exclusive Coupons
Buy 1 meal get 1 Free
B NUTRITIOUS
10% Discount
"YOUR JOURNEY TO A HEALTHIER LIFE"
JOURNEY
FITNESS
50% Off any personal training package
All employee discounts valid with proof of employment (badge, pay stub, and/or City of El Monte uniform).
For more information, please contact the Facilities, Special Programs and Events Division at (626) 258-8634
Monday - Thursday 8:30 a.m. - 5:30 p.m.
The Friendly City of El Monte

Rates

Health Insurance – Los Angeles Area Rates

Los Angeles, San Benardino, and Ventura

Plan	Employee Only		Employee + 1		Employee + Family	
	Semi-Monthly	Monthly	Semi-Monthly	Monthly	Semi-Monthly	Monthly
Anthem HMO Select	$313.54	$627.07	$627.07	$1,254.14	$815.19	$1,630.38
Anthem HMO Traditional	$439.24	$878.48	$878.48	$1,756.96	$1,142.03	$2,284.05
Blue Shield HMO	$334.88	$669.75	$669.75	$1,339.50	$870.68	$1,741.35
Health Net Salud Y Mas HMO	$178.25	$356.50	$356.50	$713.00	$463.45	$926.90
Health Net SmartCare HMO	$292.14	$584.27	$584.27	$1,168.54	$759.55	$1,519.10
Kaiser Permanente HMO	$309.32	$618.64	$618.64	$1,237.28	$804.23	$1,608.46
PERS Choice PPO	$327.25	$654.50	$654.50	$1,309.00	$850.85	$1,701.70
PERS Select PPO	$210.39	$420.77	$420.77	$841.54	$547.00	$1,094.00
PERS Care PPO	$421.89	$843.78	$843.78	$1,687.56	$1,096.92	$2,193.83
PORAC PPO	$387.00	$774.00	$811.50	$1,623.00	$1,038.00	$2,076.00
United HealthCare HMO	$334.84	$669.67	$669.61	$1,339.22	$870.50	$1,740.99

Health Insurance – Other Southern California Rates

Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, Riverside, San Diego, San Luis Obispo, Santa Barbara, Tulare

Plan	Employee Only		Employee + 1		Employee + Family	
	Semi-Monthly	Monthly	Semi-Monthly	Monthly	Semi-Monthly	Monthly
Anthem HMO Select	$312.54	$625.07	$625.07	$1,250.14	$812.59	$1,625.18
Anthem HMO Traditional	$415.45	$830.89	$830.89	$1,661.78	$1,080.16	$2,160.31
Blue Shield HMO	$380.02	$760.04	$760.04	$1,520.08	$988.05	$1,976.10
Health Net Salud Y Mas HMO	$213.91	$427.81	$427.81	$855.62	$556.16	$1,112.31
Health Net SmartCare HMO	$321.36	$642.71	$642.71	$1,285.42	$835.53	$1,671.05
Kaiser Permanente HMO	$314.32	$628.63	$628.63	$1,257.26	$817.22	$1,634.44
PERS Choice PPO	$360.56	$721.11	$721.11	$1,442.22	$937.45	$1,874.89
PERS Select PPO	$231.36	$462.71	$462.71	$925.42	$601.53	$1,203.05
PERS Care PPO	$453.65	$907.29	$907.29	$1,814.58	$1,179.48	$2,358.95
PORAC PPO	$387.00	$774.00	$811.50	$1,623.00	$1,038.00	$2,076.00
United HealthCare HMO	$323.33	$646.65	$646.65	$1,293.30	$840.65	$1,681.29

Ancillary Benefits

Plan	Employee Only		Employee + 1		Employee + Family	
	Semi-Monthly	Monthly	Semi-Monthly	Monthly	Semi-Monthly	Monthly
Cigna DHMO	$8.52	$17.03	$17.04	$34.08	$25.12	$50.23
Cigna DPPO	$24.05	$48.10	$48.20	$96.39	$69.17	$138.34
EyeMed	$4.02	$8.03	$7.68	$15.36	$11.30	$22.60
United HealthCare Spectera	$2.38	$4.76	$2.38	$4.76	$2.38	$4.76

* Contribution: City shall contribute the amount of the second lowest cost HMO family plan rate.

** Excess Contribution: Non-CalPERSable / Refer to MOU for details.

Medical Benefits: HMO

Full-time Employees

Medical	PERS
All full-time employees and their dependents are eligible for medical coverage through PERS. Dependents are eligible up to age 26.	

CalPERS

Medical HMO Comparison

	2019 Anthem Blue Cross Select & Traditional	2019 Blue Shield Access	2019 Health Net SmartCare
Annual Deductible (Individual/Family)	No deductible	No deductible	No deductible
Coinsurance	100%	100%	100%
Out-of-Pocket Limit (Individual/Family)	$1,500/$3,000	$1,500/$3,000	$1,500/$3,000
Calendar Year Deductible	100%	100%	100%
Inpatient Hospital	$15 co-pay/visit	$15 co-pay/visit	$15 co-pay/visit
Office Visit/Exam	$15 co-pay/visit	$15 co-pay/visit	$15 co-pay/visit
Outpatient Specialist	100%	100%	100%
Diagnostic Lab & X-Ray	100%	100%	100%
Adult Preventive Exams/Tests	100%	100%	100%
Well Woman Exams	100%	100%	100%
Mammograms	100%	100%	100%
Well-Child Care	100%	100%	100%
Maternity Care (Pre-Natal)	100%	100%	100%
Emergency Room	$50 co-pay; waived if admitted	$50 co-pay; waived if admitted	$50 co-pay; waived if admitted
Chiropractic Services	Not Covered	Not Covered	Not Covered
Prescription Drugs 30-day supply/90-day supply	30 days. Excludes coverage for a drug if there is an over the counter (OTC) alternative. Please note co-pays increase after 60 days for maintenance medications		
• Generic	$5 co-pay	$5 co-pay	$5 co-pay
• Brand	$20 co-pay	$20 co-pay	$20 co-pay
• Non-Formulary	$50 co-pay	$50 co-pay	$50 co-pay
Mail Order Drugs	90 day supply	90 day supply	90 day supply
• Generic	$10 co-pay	$10 co-pay	$10 co-pay
• Brand	$40 co-pay	$40 co-pay	$40 co-pay
• Non-Formulary	$100 co-pay	$100 co-pay	$100 co-pay

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Medical Benefits (continued)

CalPERS

Medical HMO Comparison (continued)

	2019 Kaiser Permanente	2019 UnitedHealthCare HMO
Annual Deductible (Individual/Family)	No deductible	No deductible
Coinsurance	100%	100%
Out-of-Pocket Limit (Individual/Family)	$1,500/$3,000	$1,500/$3,000
Calendar Year Deductible	100%	100%
Inpatient Hospital	$15 co-pay/visit	$15 co-pay/visit
Office Visit/Exam	$15 co-pay/visit	$15 co-pay/visit
Outpatient Specialist	100%	100%
Diagnostic Lab & X-Ray	100%	100%
Adult Preventive Exams/Tests	100%	100%
Well Woman Exams	100%	100%
Mammograms	100%	100%
Well-Child Care	100%	100%
Maternity Care (Pre-Natal)	100%	100%
Emergency Room	$50 co-pay; waived if admitted	$50 co-pay; waived if admitted
Chiropractic Services	Not Covered	Not Covered
Prescription Drugs 30-day supply/90-day supply	30 days. Excludes coverage for a drug if there is an over the counter (OTC) alternative. Please note co-pays increase after 60 days for maintenance medications	
• Generic	$5 co-pay	$5 co-pay
• Brand	N/A	$20 co-pay
• Non-Formulary	$20 co-pay	$50 co-pay
Mail Order Drugs	31 to 100 day supply	90 day supply
• Generic	$10 co-pay	$10 co-pay
• Brand	$40 co-pay	$40 co-pay
• Non-Formulary	N/A	$100 co-pay

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Medical Benefits: PPO

CalPERS

Medical PPO Comparison

	2019 Anthem Blue Cross PERS Choice All Employees		2019 Anthem Blue Cross PERS Select All Employees	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Individual/Family)	$500 / $1,000	$500 / $1,000	$500 / $1,000	$500 / $1,000
Coinsurance	20%	40%	20%	40%
Out-of-Pocket Limit (Individual/ Family)	$3,000 / $6,000	N/A	$3,000 / $6,000	N/A
Inpatient Hospital	20%	40%	20 - 30% (hospital tiers)	40%
Office Visit/Exam	$20 co-pay	40%	$10 co-pay	40%
Outpatient Specialist	$35 co-pay	40%	$35 co-pay (for most)	40%
Diagnostic Lab & X-Ray	20%	40%	20%	40%
Adult Preventive Exams/Tests	100%	40%	100%	40%
Well Woman Exams	100%	40%	100%	40%
Mammograms	100%	40%	100%	40%
Well-Child Care	100%	40%	100%	40%
Maternity Care (Pre-Natal)	100%	40%	20%-30%	40%
Emergency Room	$50 co-pay; waived if admitted		$50 co-pay; waived if admitted	
Chiropractic Services	20% up to 15 visits/year	40% up to 15 visits/year	20% up to 15 visits/year	40% up to 15 visits/year
Prescription Drugs 30-day Supply/90-day Supply	30 day supply. Excludes coverage for a drug if there is an over the counter (OTC) alternative. Please note co-pays increase after 60 days for maintenance medications.			
• Generic	$5 co-pay		$5 co-pay	
• Brand	$20 co-pay		$20 co-pay	
• Non-Formulary	$50 co-pay		$50 co-pay	
Mail Order Drugs	90 day supply		90 day supply	
• Generic	$10 co-pay		$10 co-pay	
• Brand	$40 co-pay		$40 co-pay	
• Non-Formulary Non-Preferred (non-formulary) brand drug co-pays are excluded from the $1,000 maximum out-of-pocket mail order spend limit	$100 co-pay		$100 co-pay	

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Medical Benefits (continued)

CalPERS

Medical PPO Comparison (continued)

	2019 Anthem Blue Cross PERS Care All Employees		2019 PORAC	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Individual/Family)	$500 / $1,000	$500 / $1,000	$300 / $900	$600 / $1,800
Coinsurance	10%	40%	10%	40%
Out-of-Pocket Limit (Individual/Family)	$2,000/$4,000	N/A	Medical: $4,500/$9,000 Pharmacy: $2,350/$4,700	N/A
Inpatient Hospital Subject to a $250/ admission deductible Add a $250 hospital co-pay per admission for bariatric surgery if you reside outside of California and choose not to use a Center of Medical Excellence.	10% plus $250 hospital admission	40% plus $250 hospital admission	10% plus $250 hospital admission	40% plus $250 hospital admission
Office Visit/Exam	$20 co-pay/visit	40%	$20 co-pay/visit	10% of a limited fee schedule
Outpatient Specialist	$35 co-pay/visit (for most)	40%	$20 co-pay/visit (for most)	10% of a limited fee schedule
Diagnostic Lab & X-Ray	10%	40%	10%	10% of a limited fee schedule
Adult Preventive Exams/Tests	100%	40%	100%	10% of a limited fee schedule
Well Woman Exams	100%	40%	100%	10% of a limited fee schedule
Mammograms	100%	40%	100%	10% of a limited fee schedule
Well-Child Care	100%	40%	100%	10% of a limited fee schedule
Maternity Care (Pre-Natal)	10% plus $250 hospital admission	40% plus $250 hospital admission	10%	10% of a limited fee schedule
Emergency Room	$50 co-pay; waived if admitted	10%	10% of a limited fee schedule	
Chiropractic Services	10% up to 20 visits/ year (combined with Acupuncture)	40% up to 20 visits/ year (combined with Acupuncture)	$20 co-pay/visit up to 20 visits/year (combined with Acupuncture)	10% of a limited fee schedule up to 20 visits/year combined

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Medical Benefits (continued)

CalPERS

Medical PPO Comparison (continued)

	Medical PPO 2019 Anthem Blue Cross PERS Care All Employees		Medical PPO 2019 PORAC	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drugs 30-day supply / 90-day supply - Excludes coverage of a drug if there is an over the counter (OTC) alternative. Please note co-pays increase after 60 days for maintenance medications.	34 days' supply	34 days' supply	30 days' supply	30 days' supply
• Generic	$5 co-pay		$10 co-pay	Partial reimbursement only
• Brand	$20 co-pay		$25 co-pay	Partial reimbursement only
• Non-Formulary	$50 co-pay		$45 co-pay	Partial reimbursement only
• Specialty Drug	N/A		$25 co-pay	Partial reimbursement only
Mail Order Drugs	90 days' supply		90 days' supply	90 days' supply
• Generic	$10 co-pay		$20 co-pay	Partial reimbursement only
• Brand	$40 co-pay		$40 co-pay	Partial reimbursement only
• Non-Formulary	$100 co-pay Non-Preferred (non-formulary) brand drug co-pays excluded from the $1,000 maximum out-of-pocket mail order spend limit.		$75 co-pay	Partial reimbursement only
• Specialty Drugs			$45 co-pay	Partial reimbursement only

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Dental: HMO/PPO

Dental PPO Plan

Dental PPO Plan	Cigna
All full-time employees of the City and their dependents are eligible for dental. Dependents are eligible up to age 26. Benefits are as follows:	
Annual Deductible	$50 individual / $150 family
Annual Benefit Maximum	$1,000
Diagnostic and Preventive Services (Oral Exams, Cleanings, X-Rays)	100% (Deductible waived)
Basic Services (Extractions, Fillings, Root Canals)	100%
Major Services (Crowns, Dentures Bridges)	50%
Orthodontia (Adults & Children)	50% $1,500 Lifetime Maximum

Dental DHMO Plan

Dental DHMO Plan	Cigna
All full-time employees of the City and their dependents are eligible for dental. Dependents are eligible up to age 26. Benefits are as follows:	
Annual Deductible	None
Annual Benefit Maximum	Unlimited
Diagnostic and Preventive Services (Oral Exams, Cleanings, X-Rays)	$0 - $50 (see full schedule of benefits for applicable copayment)
Basic Services (Extractions, Fillings, Root Canals)	$0 - $255 (see full schedule of benefits for applicable copayment)
Major Services (Crowns, Dentures Bridges)	$0 - $600 (see full schedule of benefits for applicable copayment)
Orthodontia (Adults & Children)	Child: $984 / Adult: $1,488

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.

Vision

Vision

Vision	EyeMed
All full-time employees of the City and their dependents are eligible for vision coverage. Dependents are eligible up to age 26. Benefits are as follows:	
Frequency of Benefits	
• Exam	Every 12 Months
• Lenses	Every 12 Months
• Frames	Every 12 Months
Exam Deductible	$10 Co-pay
Material Deductible	$0 Co-pay
Cosmetic Contact Lens Allowance	$150
Frame Allowance	$150

Remember with EyeMed employees and dependents have access to Freedom Pass! Freedom Pass allows employees and dependents purchasing frames at Target Optical or Sears 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.

Note: This benefit is not combinable with any other offer and is only available at Target Optical and Sears Optical.

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.

Life Insurance, AD&D and EAP

Life Insurance and Accidental Death and Dismemberment (AD&D)

Life Insurance	The Hartford
City of El Monte provides employer paid life insurance based on bargaining agreements. The amount of Life Insurance is as follows:	
All Employees	Class 1: $6,000 Class 2: $12,000 Class 3: $25,000 Class 4: $50,000

Accidental Death and Dismemberment (AD&D)	The Hartford
Those employees who are covered under the employer paid life insurance are also eligible for AD&D. The coverage amount is the same as the life insurance coverage listed above.	

Employee Assistance Program (EAP)	Managed Health Network (MHN)
The City of El Monte provides a free employee assistance program (EAP) for all regular employees and family members. This benefit is provided by Managed Health Network. The EAP can provide assistance 24 hours a day/7 days a week/365 days a year for almost any problem including (but not limited to):	
Emotional Stress Child/Elder Care Chemical Dependency Weight Management Financial Issues	Gambling Addiction Debt Management Legal Issues Relationship/Marriage/Family Issues Depression Parenting

To access the EAP, please call **800.227.1060**

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.

Section 125 (Flexible Spending Accounts)

Through a Flexible Spending Account (FSA), you use tax-free dollars to pay for:

- Most medical, dental and vision care expenses (like co-payments and deductibles)
- Dependent care expenses (day care, baby-sitters or after-school care)

How the Accounts Work

Each pay period, you simply make a pre-tax contribution to your Health Care Spending Account or Dependent Care Spending Account. Your Health Care Spending Account will be pre-loaded to a debit card to use for eligible expenses. Claim information can be submitted through our mobile application, online or by completing a claim form. Dependent Care Spending Account is similar to a checking account, dollars are only available as they are received.

How much to Contribute

The trick to using your FSA is figuring out how much to contribute each pay period. If you contribute less than the amount of your actual eligible expenses, you miss out on some tax savings. If you contribute more than the amount of your actual eligible expenses, the IRS rules state that you forfeit the extra money. Therefore, it's best to estimate a little low when deciding how much to contribute.

Filing Claims for Reimbursement

To receive reimbursement from your account, you will need to complete a claim form, provide copies of your receipts or bills and include the Social Security Number or the tax ID number of your dependent care worker for dependent care forms.

Members can use the American Fidelity Card. It is a MasterCard (or Visa) that you use at eligible providers to pay for FSA-eligible healthcare expense including prescription drugs.

American Fidelity gives you easy access to your Healthcare Flexible Spending Account (FSA) funds. Simply swipe your Card and funds are deducted from your FSA balance to pay for eligible expenses - no need to submit a claim and wait for reimbursement

	American Fidelity Section 125 Flexible Spending Account All Employees
Medical Spending Account - Maximum Annual Contribution	$2,650
Dependent Care Account - Maximum Annual Contribution	$5,000

Contact Information

Plan	Phone Number	Website
Human Resources / Risk Management	626.580.2040	
CalPERS	888.225.7377	www.calpers.ca.gov
PARS	800.540.6369	www.pars.org
Anthem Blue Cross	855.839.4524	www.anthem.com/ca/calpers
Blue Shield	800.334.5847	www.blueshieldca.com/calpers
Health Net	888.926.4921	www.healthnet.com
Kaiser Permanente	800.464.4000	www.kp.org
PORAC	800.288.6928	www.anthem.com/ca/calpers
United HealthCare	877.359.3714	www.myuhc.com
EyeMed	866.939.3633	www.eyemedvisioncare.com
Cigna	800.244.6224	www.cigna.com
American Fidelity (FSA)	800.662.1113	www.americanfidelity.com
Aflac	800.992.3522	www.aflac.com
AllState	877.810.2920	www.allstate.com
MHN (EAP)	800.227.1060	https://members.mhn.com/home Company Code: elmonte

Important Legal Notices

Discrimination Is Against the Law

City of El Monte complies with the applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. City of El Monte does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The City of El Monte:

- Provides free aids and services to people with disabilities to communicate effectively with it, such as:
  - Qualified sign language interpreters
  - Written information in other formats (e.g., large print, audio, accessible electronic formats, etc.)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact a Human Resources/Risk Management representative

If you believe that The City of El Monte has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Human Resources/Risk Management Director, Angela McCray, 11333 Valley Boulevard, El Monte, California 91731, 626.580.2040, or amccray@elmonteca.gov. You can file a grievance in person, or by mail, fax, or email. If you need help filing a grievance, Human Resources/Risk Management is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800.368.1019, 800.537.7697 (TDD)
Email: OCRMail@hhs.gov

Complaint forms are available at:

https://www.hhs.gov/sites/default/files/civil-rights-complaint-form-0945-0002-exp-04302019.pdf

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 for more information.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.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 from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.calpers.ca.gov.

Important Legal Notices (continued)

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks. 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 under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

Important Legal Notices (continued)

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

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

NOTICE AND ELECTION PROCEDURES

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

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

ELECTION AND ELECTION PERIOD

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

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

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

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

Important Legal Notices (continued)

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

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 subject to ERISA, 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.

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.

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

Important Legal Notices (continued)

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
626.580.2040
humanresources@elmonteca.gov

Important Legal Notices (continued)

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 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.**
- **The City of El Monte has determined that the prescription drug coverage offered by the CalPERS 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.

Important Legal Notices (continued)

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:	January 1, 2019
Name of Entity / Sender:	City of El Monte
Contact:	Human Resources/ Risk Management Department
Address:	11333 Valley Boulevard El Monte, CA 91731
Phone:	626.580.2040

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

The 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 a Human Resources/Risk Management Representative.

Wellness – Alternative Standards

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all participating employees. If you think you might be unable to meet a standard for a reward under the wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 626.580.2040 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you with regard to your health status.

Important Legal Notices (continued)

Important Notice Regarding Wellness Information

City of El Monte Wellness Program is a voluntary program available to all employees and is subject to federal law including the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act.

If you choose to participate, you may be asked to complete a voluntary health risk assessment that asks questions about your health-related activities and behaviors and whether you have or had certain medical conditions. You may also be asked to complete a voluntary biometric screening.

The information gathered from your health risk assessment and/or biometric screening will be used to provide you with information to help you understand your current health, potential risks, and may also be used to offer you services through the wellness program. You are also encouraged to share your results or concerns with your own doctor.

The law requires us to maintain the privacy and security of your personally identifiable health information. Although the wellness program and City of El Monte may use aggregate, non-employee specific information to design a program to address health risks in the workplace, your personal identifiable information will never be disclosed publicly or to your employer. Medical information that personally identifies you in connection with the wellness program will not be disclosed to your supervisors or managers and will never be used to make decisions regarding your employment. Anyone (e.g., a registered nurse, a doctor, health coach, etc.) who receives information about you for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

All medical information obtained through the wellness program will be maintained in the Human Resources/Risk Management Department.

If you have any questions or concerns, please contact the Human Resources/Risk Management department at 626.580.2040.

Important Legal Notices (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about City of 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 offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through Covered California begins November 1, 2018 and ends on January 31, 2019. Open Enrollment for most other states will close on December 15, 2018.

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 9.56% (for 2018) and 9.86% (for 2019) 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)** 95-6000705	
5. Employer address 11333 Valley Blvd	**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? Human Resources/Risk Management Representative		
11. Phone number (if different from above)	**12. Email address** humanresources@elmonteca.gov	

Important Legal 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 January 31, 2018. 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)

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
800.221.3943/ State Relay 711
CHP+: https://colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 800.359.1991/ State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 877.357.3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 404.656.4507

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

IOWA – Medicaid
Website:
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 888.346.9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 785.296.3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/agencies/dms
Phone: 800.635.2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 888.695.2447

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

MASSACHUSETTS – Medicaid and CHIP
Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 800.862.4840

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.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

Important Legal Notices (continued)

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://dwss.nv.gov/
Medicaid Phone: 800.992.0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603.271.5218
NH Medicaid Service Center Hotline: 888.901.4999

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609.631.2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800.701.0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800.541.2831

NORTH CAROLINA – Medicaid
Website: https://dma.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:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 800.692.7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855.697.4347

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
Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 800.432.5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 855.242.8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 800.562.3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 800.362.3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307.777.7531

To see if any other states have added a premium assistance program since January 31, 2018, 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

Key Terms to Know

Access Fee A specified dollar amount the insured person pays a health care provider toward the covered expenses of certain benefits in addition to fees for services. For example, you may pay an access fee for using emergency room services, in addition to the emergency room fees.

Coinsurance Your share of the costs of a covered health care service, calculated as a percent of the allowed amount for the service. You have to pay the deductible before you receive the coinsurance benefit. Your coinsurance share is higher for out-of-network claims.

Co-pay A flat amount you pay when you visit a health care provider or fill an in-network prescription. For example, if you enroll in the Select plan and visit your Primary Care Physician (PC), you would only pay the $20 copay.

Deductible A fixed amount you pay before any plan begins to pay. Deductibles are higher on out-of-network claims.

Drug Formulary A listing of prescription drugs and insulin established by the provider that includes both brand name prescription drugs and generic prescription drugs. Drugs listed on the formulary are covered under the prescription drug plan, with copayments. Also called "formulary".

Explanation of Benefits (EOB) A written statement from the provider that you receive after you or a provider submits a claim. The statement shows which benefits and charges the plan covers and how much they will pay.

Generic A prescription drug that is not protected by trademark registration, but is produced and sold under the chemical formulation name.

In-Network Provider A provider who contracts with the City's Plan Administrator, and provides a discount off their regular fees.

Out-of-Network The use of health care providers who have not contracted with PERS to provide services.

Out-of-Pocket Maximum This is your safety net in the medical plan that protects you from catastrophic medical expenses. Once you pay the individual maximum or family maximum, additional covered medical claims for the year are pad 100 percent by the City and you pay nothing.

Plan Year Plan year is the twelve-month period from January 1 – December 31.

Preventive Services All plans cover 100 percent of preventive service visits made to in-network providers. Mammograms, flu shots, prostate exams and well-baby visits are examples of preventive services. Note: If you discuss another health issue during a preventive service visit, you may have to pay a fee for your visit.

Keenan & Associates

Innovative Solutions. Enduring Principles.

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