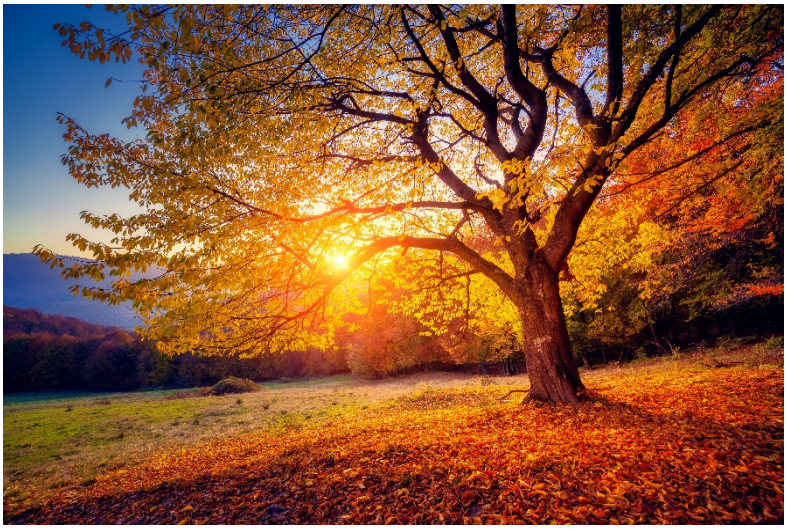


2020

Employee Benefits Overview

January 1, 2020 – December 31, 2020

Table of Contents

Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices on pages 26 - 27 for more details.

Statement of Material Modifications: This enrollment guide constitutes a Summary of Material Modifications (SMM) to the City of Redlands' Health Plans. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Explore Your Benefits

At City of Redlands we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

A list of plan contacts is included in the back of this guide.

The benefits in this summary are effective:

January 1, 2020 to December 31, 2020

Who Can You Cover?

Who is Eligible?

Full-time employees are eligible for the benefits outlined in this overview.

You can enroll the following family members in our medical, dental, and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your same or opposite sex domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit. Please review the affidavit carefully because it includes important information about the guidelines for adding, ending or changing your domestic partner. Any premiums for your domestic partner paid for by City of Redlands are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis.
- Your children (including your domestic partner's children):
    - Under age 26 are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.
    - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

Who Is Not Eligible?

Family members who are not eligible for coverage include (but are not limited to):

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

When Can I Enroll?

Coverage for new full-time employees begins on the first of the month following date of hire.

Open enrollment for current full-time employees is generally held in September. Open enrollment is the one time each year that employees can make changes to their benefit elections without a “qualifying life event.”

Make sure to notify Human Resources right away if you do have a “qualifying life event” and need to make a change (add or drop) to your coverage election. These changes include (but are not limited to):

- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage
- Divorce

You have 30 days to make your change.

What Happens If I Waive Coverage?

If an employee waives coverage in any of the benefits being offered, they will be forfeiting their eligibility, and will not be able to enroll in benefits until the next open enrollment period unless they have a “qualifying life event.”

How Do I Waive Coverage?

Contact Human Resources to complete the necessary paperwork to waive coverage and provide proof of other group coverage.

Things to Consider When Making A Plan Selection

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

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

FEATURES	HMO	PPO
Accessing health care providers	Contracts with providers (doctors, medical groups, hospitals, labs, pharmacies, etc.) to provide you services at a fixed price	Gives you access to a network of healthcare providers (doctors, hospitals, labs, pharmacies, etc.) known as preferred providers
Selecting a primary care physician (PCP)	Most HMOs require you to select a PCP who will work with you to manage your health care needs[1]	Does not require you to select a PCP
Seeing a specialist	Requires advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests	Allows you access to many types of services without receiving a referral or advance approval
Obtaining care	Generally requires you to obtain care from providers who are a part of the plan network Requires you to pay the total cost of services if you obtain care outside the HMO's provider network without a referral from the health plan (except for emergency and urgent care services)	Encourages you to seek services from preferred providers to ensure your coinsurance and co-payments are counted toward your calendar year out-of-pocket maximums[2] Allows you the option of seeing non-preferred providers, but requires you to pay a higher percentage of the bill[3]
Paying for services	Requires you to make a small co-payment for most services	Limits the amount preferred providers can charge you for services Considers the PPO plan payment plus any deductibles and co-payments you make as payment in full for services rendered by a preferred provider

[1] Your PCP may be part of a medical group that has contracted with the health plan to perform some functions, including treatment authorization, referrals to specialists, and initial grievance processing.

[2] Once you meet your annual deductible and co-insurance, the plan pays 100% of medical claims from Preferred Providers for the remainder of the calendar year; however, you will continue to be responsible for co-payments for physician office visits, pharmacy and other services, up to the annual out-of-pocket maximum.

[3] Non-preferred providers have not contracted with the health plan; therefore, you will be responsible for paying any applicable member deductibles or coinsurance, plus any amount in excess of the allowed amount.

CalPERS Health Plan Choices & Basic Features

The City of Redlands provides a variety of medical choices for you and your family. The following medical selections are available to you through CalPERS.

MEDICAL PLAN BENEFITS	Anthem Select HMO (Limited Network)	Anthem Traditional HMO (Full Network)	Blue Shield HMO (Full Network)
Benefit Plan Limits	**IN-NETWORK ONLY**	**IN-NETWORK ONLY**	**IN-NETWORK ONLY**
Calendar Year Deductible (Individual/Family)	None	None	None
Calendar Year Out-of-Pocket Maximum (Individual/Family)	$1,500 / $3,000	$1,500 / $3,000	$1,500 / $3,000
Lifetime Benefit Maximum	Unlimited	Unlimited	Unlimited
Outpatient Professional Services			
Primary Care Provider Office Visit	$15 Copay	$15 Copay	$15 Copay
Specialist Office Visit	$15 Copay	$15 Copay	Access+: $30 Copay Other: $15 Copay
Preventive Health Services	No Charge	No Charge	No Charge
Chiropractic / Acupuncture (20 visits/cal. year combined)	$15 Copay	$15 Copay	$15 Copay
Hospital Services			
Inpatient Hospital	No Charge	No Charge	No Charge
Outpatient Surgery	No Charge	No Charge	No Charge
Emergency Room (copay waived if admitted)	$50 Copay	$50 Copay	$50 Copay
Urgent Care	$15 Copay	$15 Copay	$15 Copay
Retail Pharmacy (Non-Maintenance Medications; up to a 30 day supply)			
Retail Pharmacy Calendar Year Out-of-Pocket Maximum (Individual / Family)	**Separate from Medical OOPM $6,400 / $12,800**	**Separate from Medical OOPM $6,400 / $12,800**	**Separate from Medical OOPM $6,400 / $12,800**
Generic Drugs	$5 Copay	$5 Copay	$5 Copay
Brand Name Formulary Drugs	$20 Copay	$20 Copay	$20 Copay
Brand Name Non-Formulary Drugs	$50 Copay	$50 Copay	$50 Copay
Mail Order Pharmacy (up to a 90 day supply)			
Mail Order Pharmacy Calendar Year Out-of-Pocket Maximum (Per Member)	**Separate from Medical OOPM $1,000**	**Separate from Medical OOPM $1,000**	**Separate from Medical OOPM $1,000**
Generic Drugs	$10 Copay	$10 Copay	$10 Copay
Brand Name Formulary Drugs	$40 Copay	$40 Copay	$40 Copay
Brand Name Non-Formulary Drugs	$100 Copay	$100 Copay	$100 Copay

CalPERS

Health Plan Choices & Basic Features *(continued)*

Additional medical selections available to you through CalPERS.

MEDICAL PLAN BENEFITS	Health Net Salud y Más & SmartCare HMO	Kaiser Permanente HMO	UnitedHealthcare SignatureValue Alliance HMO
Benefit Plan Limits	**IN-NETWORK ONLY**	**IN-NETWORK**	**IN-NETWORK ONLY**
Calendar Year Deductible (Individual/Family)	None	None	None
Calendar Year Out-of-Pocket Maximum (Individual/Family)	$1,500 / $3,000	$1,500 / $3,000	$1,500 / $3,000
Lifetime Benefit Maximum	Unlimited	Unlimited	Unlimited
Outpatient Professional Services			
Primary Care Provider Office Visit	$15 Copay	$15 Copay	$15 Copay
Specialist Office Visit	$15 Copay	$15 Copay	$15 Copay
Preventive Health Services	No Charge	No Charge	No Charge
Chiropractic / Acupuncture (20 visits/cal. year combined)	$15 Copay	$15 Copay	$15 Copay
Hospital Services			
Inpatient Hospital	No Charge	No Charge	No Charge
Outpatient Surgery	No Charge	$15 Copay	No Charge
Emergency Room (waived if admitted)	$50 Copay	$50 Copay	$50 Copay
Urgent Care	$15 Copay	$15 Copay	$15 Copay
Retail Pharmacy (Non-Maintenance Medications; up to a 30 day supply)			
Pharmacy Calendar Year Out-of-Pocket Maximum (Individual / Family)	**Separate from Medical OOPM $6,400 / $12,800**	**Separate from Medical OOPM $6,400 / $12,800**	**Separate from Medical OOPM $6,400 / $12,800**
Generic Drugs	$5 Copay	$5 Copay	$5 Copay
Brand Name Formulary Drugs	$20 Copay	$20 Copay	$20 Copay
Brand Name Non-Formulary Drugs	$50 Copay	N/A	$50 Copay
Mail Order Pharmacy (up to a 90 day supply)			
Pharmacy Calendar Year Out-of-Pocket Maximum (Per Member)	**Separate from Medical OOPM $1,000**	**Same as retail pharmacy (up to a 100 day supply)**	**Same as retail pharmacy Medical OOPM $1,000**
Generic Drugs	$10 Copay	$10 Copay	$10 Copay
Brand Name Formulary Drugs	$40 Copay	$40 Copay	$40 Copay
Brand Name Non-Formulary Drugs	$100 Copay	N/A	$100 Copay

Health Plan Choices & Basic Features *(continued)*

Additional medical selections available to you through CalPERS.

MEDICAL PLAN BENEFITS	PERS Select PPO	
Benefit Plan Limits	**IN-NETWORK**	**OUT-OF-NETWORK**
Calendar Year Deductible (Individual/Family)	$1,000 / $2,000*	
Calendar Year Coinsurance Out-of-Pocket Maximum (Individual/Family)	$3,000 / $6,000	N/A
Lifetime Benefit Maximum	Unlimited	
Outpatient Professional Services		
Primary Care Provider Office Visit	$35 Copay[1]	40% after deductible
Specialist Office Visit	$35 Copay	40% after deductible
Preventive Health Services	No Charge	40% after deductible
Chiropractic / Acupuncture (20 visits/cal. year combined)	$15 Copay	40% after deductible
Hospital Services		
Inpatient Hospital	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Emergency Room (copay waived if admitted)	$50 Copay + 20% after deductible	
Urgent Care	$35 Copay	40% after deductible
Retail Pharmacy (Non-Maintenance Medications; up to a 30 day supply)		
Pharmacy Calendar Year Out-of-Pocket Maximum (Individual / Family)	**Separate from Medical OOPM $2,000 / $4,000**	**N/A**
Generic Drugs	$5 Copay	Not covered
Brand Name Formulary Drugs	$20 Copay	
Brand Name Non-Formulary Drugs	$50 Copay	
Mail Order Pharmacy (up to a 90 day supply)		
Pharmacy Calendar Year Out-of-Pocket Maximum (Per Member)	**Separate from Medical OOPM $1,000**	**N/A**
Generic Drugs	$10 Copay	Not covered
Brand Name Formulary Drugs	$40 Copay	
Brand Name Non-Formulary Drugs	$100 Copay	

*There are 5 credits available to reduce your deductible to $500 / $1,000. Incentives available to reduce individual deductible (max. $500) or family deductible (max. $1,000) include: getting a biometric screening ($100 credit); receiving a flu shot ($100 credit); getting a non-smoking certification ($100 credit); getting a virtual second opinion ($100 credit); and getting a condition care certification ($100 credit) Contact your plan administrator for additional information.

[1] Reduced to $10 if enrolled with personal doctor

Health Plan Choices & Basic Features *(continued)*

Additional medical selections available to you through CalPERS.

MEDICAL PLAN BENEFITS	PERS Choice PPO	
Benefit Plan Limits	**IN-NETWORK**	**OUT-OF-NETWORK**
Calendar Year Deductible (Individual/Family)	$500 / $1,000	
Calendar Year Coinsurance Out-of-Pocket Maximum (Individual/Family)	$3,000 / $6,000	N/A
Lifetime Benefit Maximum	Unlimited	
Outpatient Professional Services		
Primary Care Provider Office Visit	$20 Copay	40% after deductible
Specialist Office Visit	$35 Copay	40% after deductible
Preventive Health Services	No Charge	40% after deductible
Chiropractic / Acupuncture (20 visits/cal. year combined)	$15 Copay	40% after deductible
Hospital Services		
Inpatient Hospital	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Emergency Room (copay waived if admitted)	$50 Copay + 20% after deductible	
Urgent Care	$35 Copay	40% after deductible
Retail Pharmacy (Non-Maintenance Medications; up to a 30 day supply)		
Pharmacy Calendar Year Out-of-Pocket Maximum (Individual / Family)	**Separate from Medical OOPM $2,000 / $4,000**	**N/A**
Generic Drugs	$5 Copay	Not covered
Brand Name Formulary Drugs	$20 Copay	
Brand Name Non-Formulary Drugs	$50 Copay	
Mail Order Pharmacy (up to a 90 day supply)		
Pharmacy Calendar Year Out-of-Pocket Maximum (Per Member)	**Separate from Medical OOPM $1,000**	**N/A**
Generic Drugs	$10 Copay	Not covered
Brand Name Formulary Drugs	$40 Copay	
Brand Name Non-Formulary Drugs	$100 Copay	

Health Plan Choices & Basic Features *(continued)*

Additional medical selections available to you through CalPERS.

MEDICAL PLAN BENEFITS	PERSCare PPO	
Benefit Plan Limits	**IN-NETWORK**	**OUT-OF-NETWORK**
Calendar Year Deductible (Individual/Family)	$500 / $1,000	
Calendar Year Coinsurance Out-of-Pocket Maximum (Individual/Family)	$2,000 / $4,000	N/A
Lifetime Benefit Maximum	Unlimited	
Outpatient Professional Services		
PCP Office Visit	$20 Copay	40% after deductible
Specialist Office Visit	$35 Copay	40% after deductible
Preventive Health Services	No Charge	40% after deductible
Chiropractic / Acupuncture (20 visits/cal. year combined)	$15 Copay	40% after deductible
Hospital Services		
Inpatient Hospital	$250 + 10% after deductible	$250 + 40% after deductible
Outpatient Surgery	$250 + 10% after deductible	$250 + 40% after deductible
Emergency Room (copay waived if admitted)	$50 Copay + 10% after deductible	
Urgent Care	$35 Copay	40% after deductible
Retail Pharmacy (Non-Maintenance Medications; up to a 34 day supply)		
Pharmacy Calendar Year Out-of-Pocket Maximum (Individual / Family)	**Separate from Medical OOPM $2,000 / $4,000**	**N/A**
Generic Drugs	$5 Copay	Not covered
Brand Name Formulary Drugs	$20 Copay	
Brand Name Non-Formulary Drugs	$50 Copay	
Mail Order Pharmacy (up to a 90 day supply)		
Pharmacy Calendar Year Out-of-Pocket Maximum (Per Member)	**Separate from Medical OOPM $1,000**	**N/A**
Generic Drugs	$10 Copay	Not covered
Brand Name Formulary Drugs	$40 Copay	
Brand Name Non-Formulary Drugs	$100 Copay	

Health Plan Choices & Basic Features *(continued)*

Additional medical selections available to you through CalPERS.

MEDICAL PLAN BENEFITS	PORAC (ASSOCIATION PLAN – AVAILABLE TO FIRE ONLY)	
Benefit Plan Limits	**IN-NETWORK**	**OUT-OF-NETWORK**
Calendar Year Deductible (Individual/Family)	$300 / $900	$600 / $1,800
Calendar Year Out-of-Pocket Maximum (Individual/Family)	$2,000 / $4,000	N/A
Lifetime Benefit Maximum	Unlimited	
Outpatient Professional Services		
PCP Office Visit	$10 / $35 Copay	20% after deductible
Specialist Office Visit	$35 Copay	20% after deductible
Preventive Health Services	No Charge	
Acupuncture	$20 Copay	20% after deductible
Chiropractic (20 visits/cal. year)	$20 Copay	20% after deductible
Hospital Services		
Inpatient Hospital	20% after deductible	20% after deductible
Outpatient Surgery	20% after deductible	20% after deductible
Emergency Room	20% after deductible (50% after deductible for non-emergency visit)	
Urgent Care	$35 Copay	20% after deductible
Retail Pharmacy (up to a 30 day supply)		
Pharmacy Calendar Year Out-of-Pocket Maximum (Individual / Family)	**Separate from Medical OOPM $3,000 / $6,000**	
Generic Drugs	$10 Copay	Member pays 100% at time of fill; paper claim may be submitted to request partial reimbursement.
Preferred Brand Drugs	$25 Copay	
Non-Preferred Brand Drugs	$45 Copay	
Specialty Drugs	$45 Copay	
Mail Order Pharmacy (up to a 90 day supply)		
Pharmacy Calendar Year Out-of-Pocket Maximum (Per Member)	**Same as retail pharmacy**	**N/A**
Generic Drugs	$20 Copay	Not covered
Preferred Brand Drugs	$40 Copay	
Non-Preferred Brand Drugs	$75 Copay	
Specialty Drugs	N/A	

Principal Financial Dental POS

Regular visits to your dentist can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

City of Redlands gives you the opportunity to enroll in a Dental Point of Service plan, administered by Principal Financial.

PRINCIPAL FINANCIAL DENTAL POS

Dental Plan Benefits	Point of Service (POS)		
	EPO Exclusive Provider Organization	PPO Preferred Provider Organization	Non-Network
Calendar Year Benefit Maximum (per member)	$2,000	$1,500	$1,500
Calendar Year Deductible (Individual/Family)	None	$50 / $150	$50 / $150
Deductible Waived for Preventive?	**Yes**	**Yes**	**No**
Diagnostic & Preventive Services	100%	100%	80% after deductible
Basic Services	**100% after deductible**	**80% after deductible**	**80% after deductible**
Major Services	100% after deductible	50% after deductible	50% after deductible
Orthodontics			
Adult & Child(ren)	All Other Members: 50%, up to $1,000 lifetime maximum Police Only: 50%, up to $1,500 lifetime maximum		

Helpful Tips:

- If you need to get extensive dental work done, make sure to submit your treatment plan to Principal Financial for an estimate of your share of costs *before treatment* is started. This way you know how much you will have to pay out-of-pocket before you receive services.
- Remember the EPO network provides the greatest discounts and preferred benefit design coverage. Try to stay within this network to get the highest benefit from your dental plan.

California Dental DHMO

In addition to the Dental POS plan through Principal Financial, City of Redlands gives you the opportunity to enroll in a Dental HMO plan administered by California Dental.

CALIFORNIA DENTAL DHMO	
Dental Plan Benefits	**DHMO**
	In-Network Only
Calendar Year Benefit Maximum (per member)	Unlimited
Calendar Year Deductible (Individual/Family)	None
Diagnostic & Preventive Services	
Oral Evaluation – 0120	No Charge
Bitewings (4 images) – 0274	No Charge
Cleanings (1 every 6 months) – 1110	No Charge ($45 Copay for additional cleanings)
Sealant (per tooth) - 1351	No Charge
Basic Services	
Fillings (4+ surfaces) – 2161/2335	No Charge
Root Canal (anterior tooth) – 3310	$50 Copay
Scaling and Root Planing (4 or more teeth per quadrant) - 4341	$20 Copay
Major Services	
Crown (full cast high noble metal) – 2790	$225 Copay
Denture – 5110 / 5120	$90 Copay (per denture)
Orthodontics	
Adult & Child(ren)	Child(ren): $1,775 Copay Adult: $1,975 Copay

Helpful Tips:

- Implants now covered!
- Don't forget about your dental cleanings!
- Keep your Fee Schedule handy. Take it with you to your dental visit. Compare what your dentist is charging you against the fee schedule. If you see a discrepancy let your provider know before signing a treatment plan.

MES Vision PPO

Routine vision exams are important, not only for correcting vision problems, but because they can detect more serious health conditions. City of Redlands provides you with the opportunity to enroll in a vision plan administered by MES Vision.

Refer to your MOU for eligibility.

MES VISION		
Plan Benefits	**In-Network**	**Out-of-Network**
Exam & Material Copayment	None	
Exam Allowance (Every 12 months)	Covered in Full	Up to $40 Allowance
Lens Allowance (Every 24 months)		
Single	Covered in Full	Up to $30 Allowance
Bifocal	Covered in Full	Up to $50 Allowance
Trifocal	Covered in Full	Up to $65 Allowance
Frame Allowance (Every 24 months)	Up to $75 Allowance	Up to $40 Allowance
Elective Contact Lens Allowance (Every 24 months)	Up to $105 Allowance	Up to $105 Allowance

Signs that you may need an eye exam:

- Sudden blurry vision or problems focusing
- Red, Dry, Itchy eyes
- You see spots, flashes of light, or floaters
- You get motion sick, dizzy or have headaches
- Eye pain or eye fatigue/strain
- Squinting or sensitivity to light

Flexible Spending Accounts (FSA)

PAYPRO ADMINISTRATORS

The City of Redlands gives you the option of enrolling in one or all of the Flexible Spending Accounts available to you through PayPro Administrators. These accounts allow you to stretch your health care and dependent care benefit dollars while reducing your overall tax burden because funds are deducted from your paycheck on a pre-tax basis. Your Benefits Debit Card **(available only for your Healthcare FSA)** makes paying for qualified expenses even easier. When you use your debit card to pay for healthcare expenses, the funds are instantly deducted from your account. You won't have to pay out-of-pocket for health care expenses, submit a claim, or wait to get reimbursed.

You have the option of enrolling in one or all of the Flexible Spending Accounts below:

Healthcare Flexible Spending Account

A **Healthcare Flexible Spending Account** is a pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plans. It's a smart, simple way to save money while keeping you and your family healthy and protected. The account does not require you to wait to use your funds – you will have access to the full amount of your annual election amount on the first day of your plan year.

You can contribute up to $2,700 into the Healthcare Flexible Spending Account, to cover eligible expenses like:

- Medical Copayments
- Prescription Medications
- Chiropractic Care
- Hospital Fees
- Medical Equipment
- Orthodontia
- Glasses / Contacts

Save Your Receipts

In many cases you won't have to send in a receipt, because with the Benefits Card, your purchases will be auto-substantiated at thousands of retailers. In some instances you will be asked to substantiate your purchase so make sure to save your receipts in the event they are requested by your plan administrator.

Dependent Care Flexible Spending Account

A **Dependent Care Flexible Spending Account** is a pre-tax benefit account used to pay for dependent care services. It is a simple way to save money while taking care of your loved ones so that you can continue to work. Unlike the Healthcare Flexible Spending Account; funds for dependent care expenses are not available until they are deducted from your paycheck and deposited into your account.

The Provider you select to utilize must have a Tax I.D. You can contribute up to $2,500 per year if you are married and file a separate tax return, or up to $5,000 per year if you are married and file a joint tax return or if you file as single, head of household. Please note that your maximum contribution may not exceed your earned income limitations.

A Dependent Care Flexible Spending Account can be used to pay for eligible, work-related expenses for the care of a qualified individual such as:

- Child Care/Babysitting
- Pre-School
- Before or After School Program
- Summer Day Camp
- Elder Care

To request reimbursement, complete the Dependent Care section of the Request Form and have the Provider sign and date. The receipt should include name, address and Tax identification number of the provider along with the from / through dates of service and total charges.

FSA Store

In addition to using your Benefits Debit Card to pay for medical expenses such as copayments, deductibles, and coinsurance at the time service is rendered. You now have the opportunity to purchase eligible health care products through the FSA Store using your Benefits Debit Card.

Simply go to https://fsastore.com/ and choose from a variety of products like:

- Contact Lenses
- Contact Lens Solution
- Band-Aids
- Sunscreen
- Blood Glucose Test Strips
- Thermometers
- First Aid Kits
- Vitamins & Supplements
- AND MUCH MORE!

PayPro Mobile App

Submitting claims through the PayPro app provides you with a convenient method of claim submission. With the simple snap of a camera, your reimbursable expenses will be securely sent to PayPro for review, with the app giving you status updates on your claim along the way. The application will automatically notify you once your submitted claim has been processed. Please visit http://www.pagroup.us/mobile/ to obtain more information on how to obtain the "What's My Balance? PayPro" application.

In addition to submitting a claim, the app allows you to:

- Check Account Balances
- Order a Replacement Benefits Card
- Keep Track of Expenses

Use It, Don't Lose It!

While it's always important to choose your annual FSA election amounts carefully, the "use it or lose it" rule no longer applies to all types of Healthcare FSAs.

Your Healthcare FSA has a grace period of 2 ½ months. This means that you can continue to incur expenses after your plan year ends.

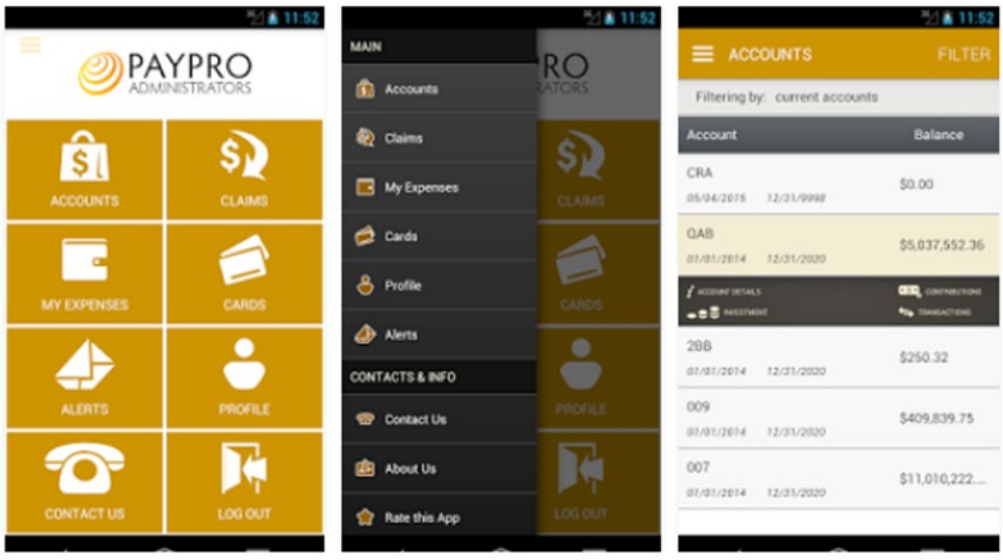
Since your plan year runs from January 1st through December 31st you have until March 15th to continue to incur healthcare expenses. Please note that claims for reimbursement must be submitted by March 31st.

Any funds remaining in your account will be forfeited.

IMPORTANT DATES

March 15th – last day to incur expenses

March 31st – last day to submit claims



Principal Financial Life and AD&D Insurance

If you have loved ones who depend on your income for support, having life and accidental death and dismemberment (AD&D) insurance can help protect your family's financial security and pay for large expenses such as housing and education, as well as day-to-day living expenses.

Basic Life/AD&D

Basic Life Insurance pays yours beneficiary a lump sum in case of your death. AD&D Insurance provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or due to death in an accident. The cost of coverage is paid in full by City of Redlands and provided by Principal Financial Group, Inc.

PRINCIPAL FINANCIAL GROUP
BASIC LIFE/AD&D FOR EMPLOYEES OF CITY OF REDLANDS

Eligible Members	All active, full-time employees (except seasonal, temporary or contract workers) who work at least 30 hours per week. If you are covered as an employee, your dependents may also be eligible. Additional eligibility requirements may apply.		
Minimum Benefit Amount	**Employee**	**Spouse**	**Child(ren)**
	$25,000	$5,000	Less than 6 months; $1,000 6 months plus: $5,000
Maximum Benefit Amount	$25,000	$5,000 (cannot exceed 50% of employee amount)	Up to $5,000 (cannot exceed 50% of employee amount)
Guaranteed Issue Amount	$25,000	$5,000	$5,000
Cost Paid by	City of Redlands	Employee	Employee

Voluntary Life/AD&D

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Principal Financial Group Inc. and paid for in full by the employee.

PRINCIPAL FINANCIAL GROUP
VOLUNTARY LIFE/AD&D FOR EMPLOYEES OF CITY OF REDLANDS

Job Class	NON COUNCIL MEMBERS		
Eligible Members	All active, full-time employees (except seasonal, temporary or contract workers) who work at least 30 hours per week. If you are covered as an employee, your dependents may also be eligible. Additional eligibility requirements may apply.		
Minimum Benefit Amount	**Employee**	**Spouse**	**Child(ren)**
	$10,000	$5,000	Under 14 days old; $1,000 Over 14 days old: $5,000 or $10,000
Maximum Benefit Amount	$500,000	$250,000 (cannot exceed 100% of employee amount)	Up to $10,000 (cannot exceed 100% of employee amount)
Guaranteed Issue Amount	Under 70: $140,000 70+: $10,000	Under 70: $30,000 70+: $10,000	Not Applicable
Cost	Paid for by Employee		

Beneficiary Reminder: Make sure that you name a beneficiary for your life insurance benefit. It's important to know that many states require that a spouse be named as the beneficiary, unless they sign a waiver.

Evidence of Insurability: If you select a coverage amount above a certain limit or if you elect to enroll outside of your initial eligibility period, you will need to submit an Evidence of Insurability form which provides information about your health in order for the insurance company to approve the requested amount of coverage.

Reliance Standard Disability Insurance

Disability income protection insurance provides a benefit for “long term” disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration. It's important to know that benefits are reduced by income from other benefits you might receive while disabled, like workers' compensation and Social Security.

RELIANCE STANDARD
LONG TERM DISABILITY

Eligibility	Active, Full-time employee working 30 or more hours per week and earning an annual salary of at least $15,000, except any person working on a temporary or seasonal basis.
Benefit Amount	60% of covered monthly earnings
Increments	$100
Minimum Benefit Amount	$500 per month
Maximum Benefit Amount	$8,000 per month
Elimination Period	90 consecutive days of total disability
Maximum Benefit Duration	Social Security Normal Retirement Age

* Elimination period refers to the time the illness or injury first occurs and when the insurance company will begin covering or paying the benefit

Reliance Standard Travel Assistance

Through your group coverage with Reliance Standard, you automatically receive travel assistance services provided by On Call International when traveling more than 100 miles from home or in a foreign country. On Call is a 24-hour, toll-free service that provides a comprehensive range of information, referral, coordination, and arrangement services designed to respond to most medical care situations and many other emergencies you may encounter when you travel. They also offer pre-trip assistance including passport/visa requirements, foreign currency and weather information. Please see the 24-Hour Travel Assistance Services flyer for more information, exclusions, and limitations about this service.

24-HOUR TRAVEL ASSISTANCE

ON CALL INTERNATIONAL

provided through

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

For emergency medical, legal and travel assistance information and referral service 24 hours a day, 365 days a year, call the numbers below. To place a collect call, dial the INTERNATIONAL COUNTRY CODE: _____ followed by On Call's collect call number.

In the U.S., toll free	Worldwide, collect
(800) 456-3893	(603) 328-1966

Travel assistance services are provided by On Call International (On Call) under the terms and conditions of a service agreement with Reliance Standard. On Call International is not affiliated with Reliance Standard or with AT&T.

Reliance Standard is not responsible for the content of the On Call travel assistance services, and is not responsible for, and cannot be held liable for, any services provided or not provided by On Call.

Reliance Standard Life Insurance Company is licensed in all states (except New York), the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands. In New York State, benefits are underwritten by First Reliance Standard Life Insurance Company, Home Office: New York, NY.

On Call is not responsible for the unavailability or results of any medical, legal or transportation services. You are responsible for obtaining all services not directly provided by On Call and for the expenses associated with them.

Employee Assistance Program

There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through MHN (Managed Health Network) is free and available to you and all members of your household. Services are confidential and available 24 hours a day, 7 days a week.

Problem – solving support

- Call us for help with life's ups and downs. We're here 24/7 to connect or refer you to a professional who can help with:
  - Marriage, family and relationship issues.
  - Stress, anxiety and sadness.
  - Grief, loss or responses to traumatic events.
  - Live webinars and on-demand library
- When you call, you can make an appointment that works for you:
  - Face-to-face sessions – Meet with a provider from our network (for example, a counselor, marriage and family therapist, or psychologist) in his or her office. We can provide a referral when you call us. You can also search or a provider on our member website.
  - Phone or web-video consultations – Easily accessed support provided by a network provider or MHN consultant.

Call: 1.800.242.6220, "Member Services", then "Benefit Inquiry or Authorization"

Or go to:

www.member.mhn.com

Access code: redlands

Work and life services

- Our experts can help you balance your work with your life!1 Call us for::
  - Childcare and eldercare assistance
  - Financial services
  - Legal services
  - Care of older adults
  - Pet care
  - Household services and more!

Legal Services

- Half hour free consultation with a participating attorney for each new legal topic (each plan year) related to:
  - General, family, criminal law
  - Elder law and estate planning
  - Divorce
  - Identity theft recovery services
  - Daily living services

Health and wellness resources

- Take charge of your well-being! Just register on our member website to:
  - Assess your health and get tips for living better.
  - Track progress toward your wellness goals.
  - Take advantage of interactive e-learning programs.
  - Find articles and videos about health topics.

The Counseling Team – Available for Safety Only

- Up to 10 sessions of assessment and referral / short term counseling per incident per calendar year
  - Available to employee and their dependents
  - Follow-up Sessions available for Safety employees involved in Critical Incidents
  - Monthly Brown Bag Seminars
  - **Call: The Counseling Team at 800-222-9691**

Colonial Life Voluntary Products

Group Accident Insurance

You can't predict when or where an accident will strike. But you can make sure you have a safety net of financial protection to help if an accidental injury occurs. Colonial Life's Group Accident Insurance helps you fill in some of the gaps caused by increasing deductibles, co-payments, and out-of-pocket costs related to an accidental injury. With this coverage you may not need to use your savings or secure a loan to help pay those unexpected out-of-pocket expenses associated with a covered accident.

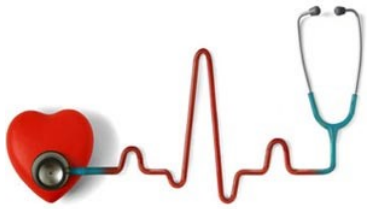
Group Specified Disease Insurance

It's true—a serious medical event such as cancer, heart attack, or stroke could leave you in a period of financial difficulty. Even if you have major medical coverage, there are typically uncovered expenses to consider, such as deductibles and co-payments, travel expenses to and from treatment centers and the loss of wages or salary.

This specified disease coverage from Colonial Life offers the protection you need to concentrate on what is most important – your treatment, care, and recovery.

Covered Critical Illness Conditions:

- Heart Attack (Myocardial Infarction)
- Stroke
- End Stage Renal (Kidney) Failure
- Major Organ Failure[1]
- Coma
- Permanent Paralysis Due to a Covered Accident
- Blindness
- Coronary Artery Bypass Graft Surgery/Disease[1]



Group Short-Term Disability Insurance

You never know when a disability could impact your way of life. Fortunately, there's a way to help protect your income. If an injury or sickness prevents you from earning a paycheck, disability insurance can provide a monthly benefit to help you cover your ongoing expenses.

PLEASE NOTE: These products are offered with guarantee issue underwriting during open enrollment only. This means no health questions will be asked up to stated limits. Pre-existing conditions and other restrictions apply. Please see your Colonial Life benefits counselor for more information.

[1] Benefit for Coronary Artery Disease in lieu of benefit for Coronary Artery Bypass Graft Surgery when Health Savings Account (HSA) compliant plan is selected. Major Organ Failure is not included with the HSA-compliant plan.

More Information to Follow Regarding Colonial Life Open Enrollment!

2020 City of Redlands' Medical Premium Contributions

Bargaining Unit	City of Redlands Premium Contributions		
	Employee Only	Employee + One Dependent	Employee + Family
RPFA Unit: Employees hired before October 16, 2012.	$720.79	$1,441.54	$1,874.03
RPFA Unit: Employees hired after October 16, 2012.	$600.00	$800.00	$1,000.00
RAFME Unit: Employees hired before October 16, 2012.	$720.79	$1,441.54	$1,874.03
RAFME Unit: Employees hired after October 16, 2012.	$400.00	$600.00	$800.00
RPOA Unit: Employees hired before November 4, 2014.	$720.31	$1,440.59	$1,872.79
RPOA Unit: Employees hired after November 4, 2014.	$600.00	$900.00	$1,100.00
RASME Unit: Employees hired before June 2, 2015	$720.31	$1,440.59	$1,872.79
RASME Unit: Employees hired after June 2, 2015	$900 for all tiers		
TEAMSTERS/RAME/RAMME/RCSEA Units: Employees hired before March 11, 2010.	$635.68	$1,271.32	$1,652.74
TEAMSTERS/RAME/RAMME/RCSEA Units: Employees hired after March 11, 2010.	$900 for all tiers		

2020 CalPERS Monthly Medical Premium Rates

2020 – Monthly Medical Premium Rates

Medical Plan	Employee Only	Employee & One Dependent	Family
Anthem HMO Select	$619.93	$1,239.86	$1,611.82
Anthem HMO Traditional	$902.63	$1,805.26	$2,346.84
Blue Shield Access+ HMO	$813.17	$1,626.34	$2,114.24
Health Net Salud y Más HMO	$392.31	$784.62	$1,020.01
Health Net SmartCare HMO	$648.42	$1,296.84	$1,685.89
Kaiser Permanente HMO	$664.39	$1,328.78	$1,727.41
PERS Choice PPO	$710.29	$1,420.58	$1,846.75
PERS Select PPO	$435.74	$871.48	$1,132.92
PERS Care PPO	$931.12	$1,862.24	$2,420.91
UnitedHealthcare Alliance HMO	$668.31	$1,336.62	$1,737.61
PORAC *(Fire Only)*	$699.00	$1,39900	$1,894.00

2020 Dental and Vision Monthly Premium Rates

Dental or Vision Plan	Employee Only	Employee & One Dependent	Family
CA Dental DHMO	$14.45	$25.69	$39.28
Principal Financial Dental PPO	$40.82	$78.15	$127.37
MES Vision	$7.25	$14.50	$18.80

Nationwide Pet Insurance

Nationwide pet insurance is now available to you as a voluntary benefit! Nationwide offers affordable healthcare plans for dogs, cats, birds and exotic pets. You're free to visit any veterinarian, anywhere—even specialists and emergency providers.

All Nationwide pet insurance members receive free, 24/7 access to Vet Helpline for guidance on any pet health concern. This service is available exclusively from Nationwide.

How to apply for Nationwide Pet Insurance

Choose from two easy ways to sign up:

Call (877) 738-7874 to find out more information about the exclusive plan you are eligible for and get a no-obligation quote.

Visit: www.petinsurance.com/cityofredlands and enter your company name to enroll online. The rates given include your discount.

Ben-IQ

MEET BEN-IQ

Ben-IQ is a free app that includes much of the information that's included in this overview, but in a place that's always at your fingertips - your smartphone. Ben-IQ is available for Android and iPhone.

Simply download Ben-IQ and enter the Employer Key: Redlands19

Take a tour of Ben-IQ and review plan summaries, and important contacts like our EAP. Store and organize ID cards using your phone's camera, and much more! Be sure to share Ben-IQ with your covered family members and caregivers too.

Words You Need to Know

Health insurance seems to have its own language. You will get more out of your plans if you understand the most common terms, explained below in plain English.

MEDICAL

OUT-OF-POCKET COST - A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

DEDUCTIBLE - The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

GENERIC DRUG - A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

DENTAL

BASIC SERVICES - Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTIC AND PREVENTIVE SERVICES - Generally include routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES - Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Important Plan Notices and Documents

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this Notice carefully to make sure you understand your rights and obligations.

NOTICE OF AVAILABILITY OF HIPAA PRIVACY NOTICE

The Federal Health Insurance Portability and Accountability Act of 1966 ("HIPAA") requires that we periodically remind you or your right to receive a copy of the HIPAA Privacy Notice. You can request a copy of the Privacy Notice by contacting Human Resources.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in **City of Redlands'** medical plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in a **City of Redlands'** medical plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request medical plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in **City of Redlands'** medical plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another medical plan.

AVAILABILITY OF SUMMARY OF BENEFITS & COVERAGE (SBC)

As an employee, the health benefits provided by **City of Redlands** represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

The **City of Redlands** offers a variety of benefit plans to eligible employees. The federal healthcare reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, information summary of benefits available under a plan.

SUMMARY OF BENEFITS AND COVERAGE AVAILABLE

CALPERS MEDICAL PLANS

Upon request, printed copies of current SBCs and applicable revisions and amendments can also be obtained by contacting CalPers.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your medical plan's Member Services.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator.

NOTICE OF CHOICE OF PROVIDERS

The CalPers HMO generally 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. If the plan designates a primary care provider automatically, insert: Until you make this designation, Pinnacle designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact CalPers.

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

You do not need prior authorization from CalPers 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, contact CalPers.

RULES FOR BENEFIT CHANGES DURING THE YEAR

Other than during annual open enrollment, you may only make changes to your benefit elections if you experience a qualified status change or qualify for a "special enrollment." If you qualify for a mid-year benefit change, you may be required to submit proof of the change or evidence of prior coverage.

QUALIFIED STATUS CHANGES INCLUDE:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, and death of a spouse
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child
- Change in employment status that affects benefit eligibility, including the start or termination of employment by your, your spouse, or your dependent child
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- Change in place of residence or worksite, including a change that affects the accessibility of network providers
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child
- An event that is a "special enrollment" under the Health Insurance Program (CHIP) Reauthorization Act. Under provisions of the Act, employees have 60 days after the following events to request enrollment:
    - Employee or dependent loses eligibility for Medicaid (known as Medi-Cal in CA) or CHIP (known as Health Families in CA);
    - Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP

    Two rules apply to making changes to your benefits during the year:

    - Any changes you make must be consistent with the change in status, AND
    - You must make the changes within 30 days of the date of the event (marriage, birth, etc.) occurs (unless otherwise noted above)

Medicare Part D Notice

IMPORTANT NOTICE FROM CITY OF REDLANDS ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Redlands 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. City of Redlands has determined that the prescription drug coverage offered by the CalPers is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your City of Redlands coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under CalPers is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your City of Redlands prescription drug 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 City of Redlands 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 plan administrator for your selected plan.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through City of Redlands changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
• Visit medicare.gov
• Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
• Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

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

Date:	January 1, 2020
Name of Entity/Sender:	City of Redlands
Contact-Position/Office:	Human Resources
Address:	35 Cajon St., Suite 10 Redlands, CA 92373
Phone Number:	(909) 798-7514

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-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:
1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/
State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

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: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website:
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

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: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid
Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremium paymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

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 August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512. The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137. OMB Control Number 1210-0137 (expires 12/31/2019)

Plan Contacts

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website
Medical	CalPERS	888-225-7377	www.calpers.ca.gov
Dental POS	Principal Financial Group	800-247-4695	www.principal.com
Dental DHMO	California Dental	877-433-6825	www.caldental.net
Vision	MES Vision	800-877-6372	www.mesvision.com
Basic Life/AD&D	Principal Financial Group	800-245-1522	www.principal.com
Voluntary Life/AD&D	Principal Financial Group	800-245-1522	www.principal.com
Long Term Disability	Reliance Standard	800-351-7500	www.rsli.com
Flexible Spending Accounts	PayPro Administrators	951-656-9273	www.pagroup.us
Employee Assistance Program	MHN	800-242-6220	www.members.mhn.com access code: redlands
Employee Assistance Program (Available to Safety Only)	The Counseling Team	800-222-9691	
Voluntary Products	Colonial Life	800-325-4368	www.coloniallife.com
Human Resources			
Liz Marin	Human Resources Manager	909-798-7540	emarin@cityofredlands.org
Michelle Vizcarra	Human Resources Specialist	909-798-7514 x 1728	mvizcarra@cityofredlands.org
Alliant Insurance Services			
Debby Miller	Account Executive	619-849-3778	debby.miller@alliant.com
Tracy Graham	Account Manager	619-849-3979	tracy.graham@alliant.com

The information in this brochure is a general outline of the benefits offered under City of Redlands benefits program. This brochure may not include all relevant limitations and conditions. Specific details and limitations are provided in the plan documents, which may include a Summary Plan Description (SPD), Evidence of Coverage (ECO), and/or insurance policies. The plan documents contain the relevant plan provisions. If the information in this brochure differs from the plan documents, the plan documents will prevail.

Alliant
EMPLOYEE BENEFITS