Employee Benefits Guide

2024

CITY OF
HERMOSA BEACH

Employee Benefits Guide 2024

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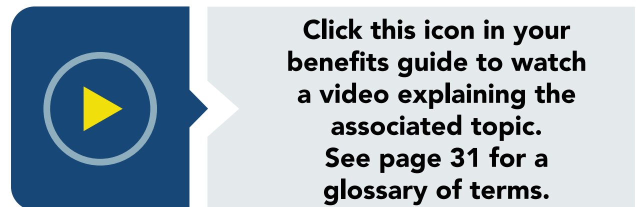

Click this icon in your benefits guide to watch a video explaining the associated topic. See page 31 for a glossary of terms.

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 22 for more details.

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

Benefits At A Glance

Your benefits are an important part of your overall compensation. We are pleased to offer a comprehensive array of quality benefits to protect your health, your family and your way of life. This enrollment guide was designed to answer some of the basic questions you may have about your benefits. Please read it carefully along with any supplemental materials you receive. If there is a discrepancy between the summaries and the written legal plan documents, the plan documents shall prevail. If you have any questions, please contact Vanessa Godinez at 310-318-0202 or vgodinez@hermosabch.org.

Benefits

Medical (1/1/24 - 12/31/24)

- Blue Shield Trio HMO Zero Admit 20*
- Blue Shield Local Access+ HMO (Narrow) Zero Admit 20*
- Blue Shield Access+ HMO (Full) Zero Admit 20*
- Blue Shield Full PPO Combined Ded 35 500 80/60

Dental (1/1/24 - 12/31/24)

- Liberty Dental HMO*
- Ameritas Fusion PPO

Vision (1/1/24 - 12/31/24)

- Ameritas (VSP & EyeMed) Vision

Life & AD&D

- Mutual of Omaha Life & AD&D**

Short Term Disability (1/1/24 - 12/31/24)

- Mutual of Omaha**

Long Term Disability (1/1/24 - 12/31/24)

- Mutual of Omaha**

Additional Benefits

- Colonial Supplement Insurance
- Employee Assistance Program
- Employee Discount & Rewards Program
- Prescription Drug Discount Program

* Only available to residents of California

** Based upon Employee's Memorandum of Understanding (MOU)

Eligibility

You are eligible for benefits if you are a full time employee. You may also enroll your eligible family members under certain plans you choose for yourself. Eligible family members include legally married spouse, domestic partner and children up to age 26.

When Coverage Begins

For new employees, coverage is effective on the first of the month following date of hire. If you fail to enroll on time, you will NOT have benefits coverage. Changes made during our annual Open Enrollment period are effective on January 1st.

Choose Carefully!

The choices you make during your initial eligibility period and annual Open Enrollment period are generally effective for the entire plan year. You may not make changes, or add or remove dependents, until the next annual Open Enrollment period unless you have a qualifying event. Examples of a qualifying event include marriage or divorce, birth or adoption, and change in eligibility status. To make a change, you MUST contact HR within 31 days of the event.

How To Enroll

Follow the detailed instructions on page 16 of this guide.

Blue Shield of California Medical HMO Plans

We offer medical and prescription drug benefits through Blue Shield of California. With an HMO plan, you select a Primary Care Physician from the participating network of providers who will coordinate your healthcare needs including referrals to specialists and approving further medical treatment. Services received outside of the HMO network are not covered, except in the case of emergency medical care. The chart below provides a high level overview of your medical plan options.

Features	Trio HMO Zero Admit 20	Local Access+ HMO (Narrow) Zero Admit 20	Access+ HMO (Full) Zero Admit 20
Preventative Care	No Charge	No Charge	No Charge
Physician Visit	$20	$20	$20
Specialist Visit	$20	$20/$35 self-referral	$20/$35 self-referral
Teledoc Consultation	No Charge	No Charge	No Charge
Lab / X Ray	No Charge	No Charge	No Charge
Urgent Care	$20	$20	$20
Emergency Room	$100	$100	$100
Outpatient Surgery			
• Ambulatory Surgical Center	No Charge	No Charge	No Charge
• Hospital	No Charge	No Charge	No Charge
Inpatient Hospital	No Charge	No Charge	No Charge
Prescription Drugs			
• Annual Rx Deductible	None	None	None
• Tier 1 *(typically Generic)*	$10	$10	$10
• Tier 2 *(typically Preferred Brand)*	$15	$15	$15
• Tier 3 *(typically Non-Preferred Brand)*	Not Covered*	Not Covered*	Not Covered*
• Tier 4 *(Specialty Medications)*	20% up to $250/prescription	20% up to $250/prescription	20% up to $250/prescription
Annual Deductible			
• Individual	None	None	None
• Family	None	None	None
Out of Pocket Maximum			
• Individual	$1,500	$1,500	$1,500
• Family	$3,000	$3,000	$3,000

* Tier 3 Drugs require a formulary exception. If approved, you pay your applicable Tier 2 Copayment or Coinsurance.

Coinsurance percentages and copay amounts shown represent what the member is responsible for paying To see a list of providers, visit www.blueshieldca.com/fad

Make the Most of Your Benefits

- Download the Blue Shield of California mobile app to keep track of your health and benefits
- Seek care from in network professionals only
- Take advantage of the 90 day prescription mail order program (Tier 1 = $20; Tier 2 = $30)

CLICK HERE to watch a video on Health Maintenance Organizations (HMO)

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.

Blue Shield of California Medical PPO Plan

We offer medical PPO coverage through Blue Shield of California. PPO plans give you the freedom to seek care from the provider of your choice; however, you will maximize your benefits and reduce your out of pocket costs if you choose a provider who participates in the Blue Shield of California network. The chart below provides a high level overview of your medical plan option.

Features	Full PPO Combined Deductible 35 500 80/60
Preventative Care	No Charge
Physician Visit	$35
Specialist Visit	$35
Teledoc Consultation	No Charge
Lab / X Ray	$35*
Urgent Care	$35
Emergency Room	$150 + 20%
Outpatient Surgery	
• Ambulatory Surgical Center	10%*
• Hospital	25%*
Inpatient Hospital	20%*
Prescription Drugs	
• Annual Rx Deductible	None
• Tier 1 *(typically Generic)*	$10
• Tier 2 *(typically Preferred Brand)*	$30
• Tier 3 *(typically Non-Preferred Brand)*	$50
• Tier 4 *(Specialty Medications)*	30% up to $250/prescription
Annual Deductible	
• Individual	$500
• Family	$1,500
Out of Pocket Maximum	
• Individual	$4,000
• Family	$8,000

Benefits illustrated above reflect in network services only. For a list of non network services, refer to the plan documents.
Coinsurance percentages and copay amounts shown represent what the member is responsible for paying.
* Benefits with an asterisk require that the deductible be met before the plan begins to pay.
To see a list of providers, visit www.blueshieldca.com/fad

Make the Most of Your Benefits

- Use in network providers
- Utilize your preventative services (vaccinations, screenings)
- Know and understand your costs up front

CLICK HERE to watch a video on Preferred Provider Organizations (PPO)

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Preventative Care Services

Get the most out of your coverage by taking advantage of preventative care coverage. Your first step in a healthier direction starts with prevention, and good prevention starts early and continues throughout your entire life. Even if you feel fine, going to the doctor for health tests and checkups is part of living a healthy life. Health screenings check for problems early, before you feel signs of sickness. Finding problems early often gives you more care choices with better results.

With your medical plan, preventative care services are covered at no cost, even before you meet the plan's deductible.

Below is a partial list of preventative care services:

- Routine physical exam
- Well baby and childcare
- Immunizations
- Bone density tests
- Cholesterol screenings
- Mammograms
- Pap smears/pelvic exams
- Prostate test
- Lab procedures
- Screenings for HIV, HPV and domestic violence
- Breastfeeding supplies
- Contraceptive drugs, devices and sterilization
- Smoking cessation

Liberty Dental HMO Plan

We offer dental benefits through Liberty Dental. With a dental HMO plan, you choose a primary dental provider to manage your care. There are no charges for most preventative services, no claim forms, and no deductibles. Reduced, pre set charges apply to other services. The chart below provides a high level overview of your dental plan option.

Features	HMO LDP-400
Annual Deductible	None
Preventative Services *(cleaning, x-rays)*	$0
Basic Services *(fillings, oral surgery)*	$0 - $105
Major Services *(complete denture, maxillary)*	$85
Annual Maximum	None
Waiting Period	None
Orthodontia	$1,775/Children, $1,950/Adults

This is only a summary of the plan benefits. The complete Benefit Schedule and Evidence of Coverage must be consulted to determine exact copays, terms, limitations, and exclusions of coverage.

Why Dental Insurance

Did you know that a routine dental examination can detect symptoms of more than 125 diseases, including heart disease, diabetes, anemia and kidney disease?

We understand how important your health and well being are. Stay on track with a comprehensive dental plan.

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Ameritas Fusion PPO Dental Plan

FUSION: THE ULTIMATE CHOICE℠ combines dental and eye care benefits in one easy-to-administer plan. This plan combines the annual maximum between the dental and eye care plans.

For the maximum:

- Each enrolled family member has up to $2,500 per year to use toward any covered dental expense (in or out-of-network).
- Each enrolled family member can use up to $100 towards any covered eye care expense.
- The total benefits paid between both dental and vision will not exceed $2,500.
- You have the freedom to see visit any licensed dentist you choose, but accessing services from in-network providers saves you money.
- The Fusion PPO dental plan includes orthodontia coverage for adults and children.
- The Fusion PPO plan allows qualifying members to carryover part of their unused annual maximum

Ameritas Fusion PPO Dental		
Plan Benefit	**In-Network**	**Out-of-Network**
Network	Ameritas Classic Plus Network	None
Allowance	Discounted Fee	90th U & C
Deductible	$50 per person Lifetime Waived for Type 1 Services	$50 per person Lifetime Waived for Type 1 Services
Benefit Maximum	$2,500 per member per calendar year	$2,500 per member per calendar year
Type 1 • Exams • X-rays • Cleanings	100% (deductible waived)	100% (deductible waived)
Type 2 • Fillings • Endodontics • Periodontics • Extractions	100%	80%
Type 3 • Onlays • Crowns • Implants • Dentures	50%	50%
Orthodontia	$2,000 per person Lifetime Max	$2,000 per person Lifetime Max
• Adults	50%	50%
• Children	50%	50%
Dental Rewards	Included	Included
EyeCare	Up to $100	Up to $100

Dental Rewards		
This dental plan includes a valuable feature that allows qualifying plan members to carryover part of their unused annual maximum. A member earns dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount for benefits received for that year. Employees and their covered dependents may accumulate rewards up to the stated maximum carryover amount, and then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan member doesn't submit a dental claim during a benefit year, all accumulated rewards are lost. But he or she can begin earning rewards again the very next year.		
Benefit Threshold	$750	Dental benefits received for the year cannot exceed this amount.
Annual Carryover Amount	$400	This Dental Rewards amount is added to the following year's maximum.
Maximum Carryover	$1,200	This is the maximum possible accumulation for Dental Rewards.

Finding Providers

To find a provider, visit ameritas.com and select **FIND A PROVIDER**, then **DENTAL**. Enter your criteria to search by location or for a specific dentist or practice. California Residents: When prompted to select your network, choose the Ameritas Network found on your ID Card or contact Customer Connections at 800-487-5553.

Your provider network is Ameritas Classic Plus Network.

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Ameritas (VSP & EyeMed) Plans

We offer vision benefits through Ameritas. These plans offer you the freedom and flexibility to use the vision provider of your choice; however, you will maximize your benefits and reduce your out of pocket costs if you choose a provider who participates in the VSP or EyeMed networks. The chart below provides a high level overview of your vision plan option.

Ameritas Vision Plans	VSP - Focus		EyeMed – ViewPointe Plan H	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Network	Choice + Affiliates	N/A	Insight	N/A
Features				
Exam	Covered in full	Up to $45	Covered in full	Up to $35
Prescription Glasses				
• Single	Covered in full	Up to $30	Covered in full	Up to $25
• Bifocal	Covered in full	Up to $50	Covered in full	Up to $40
• Trifocal	Covered in full	Up to $65	Covered in full	Up to $55
• Lenticular	Covered in full	Up to $100	20% Discount	No benefit
Frames				
• Allowance	$150	Up to $70	$150	Up to $75
Contact Lenses				
• Elective	Up to $150	Up to $120	Up to $150	Up to $120
• Medically Necessary	Covered in Full	Up to $210	Covered in Full	Up to $200
Frequency				
• Exams	Every 12 months		Every 12 months	
• Lens	Every 12 months		Every 12 months	
• Frames	Every 12 months (based on date of service)		Every 12 months (based on date of service)	

Both VSP and EyeMed offer additional savings and discounts. To Learn more, refer to the plan summaries available in Ease.

VSP Eye Care Plan Member Service

Focus eye care from Ameritas Group features the money-saving eye care network of VSP. Customer service is available to plan members through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

VSP Call Center: 800-877-7195

- Service representative hours:
  5 a.m. to 7 p.m. PST Monday through Friday,
  6 a.m. to 2:30 p.m. PST Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at: ameritas.com

View plan benefit information at: vsp.com

EyeMed Eye Care Plan Member Service

ViewPointe eye care from Ameritas Group features the money-saving eye care network of EyeMed Vision Care. Customer service is available to plan members through EyeMed's well-trained and helpful service representatives. Call or go online to locate the nearest EyeMed network provider, view plan benefit information and more.

EyeMed Customer Care Center: 866-289-0614

- Service representative hours:
  8 a.m. to 11 p.m. ET Monday through Saturday,
  11 a.m. to 8 p.m. ET Sunday
- Interactive Voice Response available 24/7

Locate an EyeMed provider at: ameritas.com

View plan benefit information at: eyemedvisioncare.com

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Mutual of Omaha Basic Life & AD&D Plan

We provide employees with life and accidental death and dismemberment (AD&D) insurance through Mutual of Omaha. The life insurance benefit is payable to the designated beneficiary upon the death of the insured. The AD&D insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot or eye). If death occurs from an accident, both benefits would be payable. The chart below provides a high level overview of your life AD&D plan option.

Features	Life & AD&D
Life Benefit	Based upon Employee's Memorandum of Understanding (MOU). For further details on this benefit, please contact Vanessa Godinez at 310-318-0202 or vgodinez@hermosabch.org.
AD&D Benefit	
Benefit Reduction	

Mutual of Omaha Short Term Disability / Long Term Disability Plan

We provide employees with disability insurance through Mutual of Omaha. If you become disabled and can't work, no benefit becomes more important to your financial security than disability income protection. As an eligible employee, you are automatically covered by this plan at no cost to you.

Features	Short Term Disability / Long Term Disability
Percentage of Income Replaced	Based upon Employee's Memorandum of Understanding (MOU). For further details on this benefit, please contact Vanessa Godinez at 310-318-0202 or vgodinez@hermosabch.org.
Maximum Benefit	
Benefit Duration	

Why a Disability Plan

Over 36 million Americans are classified as disabled. More than 50% of those disabled Americans are in their working years.

A disability plan provides income replacement if you experience a covered illness or injury. The coverage can help with everyday bills, such as mortgage or rent, that continue when you can't work or expenses that health insurance won't cover.

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Voluntary Term Life & AD&D

Life insurance is about more than just covering expenses. Depending on your circumstances, it could take your family years to recover from the loss of your income. Voluntary life insurance can provide the extra income your family may need to cover mortgage and rent payments, legal or medical fees, childcare, tuition, and any outstanding debts. Everyone's life insurance needs are different, depending on their family situation. That's why group life insurance through your employer can be an easy and affordable option.

Guarantee Issue is available to new hires. Amounts over the Guarantee Issue will require a health application/evidence of insurability. For late entrants, all amounts will require a health application/evidence of insurability.

Coverage Guidelines	Minimum	Guarantee Issue	Maximum
For You	$10,000	5x annual salary, up to $100,000	$500,000, in increments of $10,000, but no more than 5 times annual salary
Spouse	$5,000	100% of employee's benefit, up to $30,000	100% of employee's benefit, in increments of $5,000, up to $250,000
Children	$2,000	100% of employee's benefit	100% of employee's benefit, in increments of $1,000, up to $10,000
AD&D Benefit	For you, your spouse and your dependent child(ren): The Principal Sum amount is equal to the amount of the life insurance benefit. AD&D coverage is available if you or your dependents are injured or die as a result of an accident, and the injury or death is independent of sickness and all other causes.		
Annual Benefit Amount Increase	If you enroll for even the minimum amount of coverage during your initial enrollment, you can increase your coverage at your next enrollment by up to $10,000, provided the total amount of insurance does not exceed your maximum benefit amount. This feature allows you to secure additional life insurance protection in the event your needs change (ex. you get married or have a child). Amounts over the Guarantee Issue will require evidence of insurability (proof of good health).		

Mutual of Omaha Value Add Services

Mutual of Omaha – Additional Programs Available to All Employees

Employee Assistance Program

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral and mental health topics.

mutualofomaha.com/eap

or call: 800-316-2796

Travel Assistance

Enjoy Your Trip – Mutual of Omaha Will Be There – 24/7

Travel Assistance can help you avoid unexpected bumps in the road anywhere in the world. For you, your spouse and dependent children on any single trip, up to 120 days in length, more than 100 miles from home.

Services available for business and personal travel.

For inquiries within the U.S. call toll free: 800-856-9947

Outside the U.S. call collect: 312-935-3658 Worldwide Travel Assistance

Amplifon Hearing Care

Accessing Your Benefits is as Easy as ...

1. Call Amplifon at 888-534-1747 and a Patient Care Advocate will assist you in finding a hearing care provider near you.
2. Our advocate will explain the Amplifon process, request your mailing information and assist you in making an appointment with a hearing care provider.
3. Amplifon will send information to you and the hearing care provider. This will ensure your Amplifon discounts are activated.

Will Preparation Services

Creating a will is an important investment in your future. It specifies how you want your possessions to be distributed after you die. Whether you're single, married, have children or are a grandparent, your will should be tailored for your life situation.

Create your will at www.willprepservices.com and use the code MUTUALWILLS to register

Visit Ease for additional plan details.

Employee Assistance Program

Our EAP provides unlimited face-to-face counseling services per household unit, per problem area, per year with local licensed therapists.

- 1 to 5 Sessions - $0.00 copay
- 6+ Sessions - $10.00 copay

The EAP can be used for confidential assistance with problems involving:

- Marriage and Family
- Adolescent Behavior
- Substance Abuse
- Stress
- Depression
- Job-related Issues
- Emotional Difficulties
- Legal & Financial
- Grief
- and much more…

Our EAP also offers…

- A toll-free, nationwide 800 number staffed by licensed therapists available to help you 24/7 in a crisis.
- A Free 30-minute phone consultation with a licensed attorney for each legal matter you encounter. You will also receive a 255 discount if you choose to retain the attorney after your consultation.
- Free phone consultation with a financial management expert.
- Unlimited access to a legal and financial services website with information on thousands of legal issues. Over 45 financial calculators, and access to 100% accurate state-specific forms.
- Free Will, End-of-Life, and Retirement Kits, as well as an Estate Planning Checklist.
- Prescription Drug Discount Card.
- Unlimited access to wellness articles, links, and other resources on Holman's website.
- Unlimited community referrals for childcare, elder care, chemical dependency groups and more…
- An enrollee will forfeit one session for any free sessions not kept except in cases where the contracted provider is notified at least twenty-four (24) hours in advance of the appointment that it will not be kept.
- For copay sessions, an enrollee will be charged the applicable copay or the sum of thirty-five ($35.00) (which ever is greater) directly to the contracted provider for any appointment made with contracted provider and not kept, except I the case where the contracted provider is notified at least twenty-four (24) hours in advance of the appointment that it will not be kept.
- **For additional Mental Health/Chemical dependency coverage:** consult your medical insurance.
- **Out-of-Network Benefits:** No Benefit (Employees are responsible for any services provided by an out-of-network provider or facility).
- **Extra Benefits: LifeSolutions –** Daily Living, Elder Care, Child Care, Adoption, College & Prenatal Services.

Employees are eligible for benefits on the 1st of the month following 30 days of employment. Dependents include the employee's lawful spouse, domestic partners, dependent children to age 26 and anyone living in the employee's household. Benefit renews annually on January 1st.

www.Holmangroup.com

User Name: holmangroup; **Password:** hb2285 (case sensitive)

To arrange a confidential appointment call: 800-321-2843 or visit www.holmangroup.com

An EAP counselor is available 24 hours a day, 7 days a week for emergency and urgent assistance. To schedule an appointment, receive a community referral, or for inquiries our office is open 7:30 am to 6:30 pm PST.

The Holman Group
Managed Behavioral Health Care Services

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Flexible Spending Accounts

STERLING ADMINISTRATION

What are Flexible Spending Accounts?

A flexible spending account (FSA) lets you save money by setting aside pre-tax dollars to pay for eligible expenses, including:

- **Healthcare FSA:** Medical, dental, and vision expenses (including copays, deductibles, glasses, and other eligible healthcare expenses not reimbursed by your health plans)
- **Dependent Care FSA:** Daycare expenses incurred by you, your spouse, or your eligible dependents.

What are the Advantages of Flexible Benefit Plans?

Employees can reduce taxable income and use the savings to pay for qualified expenses. Tax savings include federal income tax, and in most jurisdictions, state, and local income taxes. In addition, employees do not pay Social Security and Medicare tax on the amount excluded from income.

Putting money into an FSA decreases your taxable income, which means you will take home more money.

Healthcare FSA

With a Healthcare FSA, you can be reimbursed for medical expenses not covered or reimbursed by other insurance or plans like health savings accounts (HSAs) and health reimbursement arrangements (HRAs). All expenses must be qualified medical, vision, pharmacy or dental benefit expenses as defined by Section 213(d) of the IRS Code. All medical care expenses must be incurred during the plan year and the "use it or lose it" rule applies.

All of your Healthcare FSA dollars are available on the first day of the plan year. For example, if you choose to contribute $1,200 to your FSA, your contributions will be deducted evenly across all of your paychecks for the year, but you have access to all $1,200 on Day 1.

Carryover: Any balance remaining in your Health Care Reimbursement Account at the end of the Plan Year, up to $610, will be carried forward and used to fund such benefits in any subsequent Plan Year. This carryover amount will not affect your ability to contribute the maximum amount ($3,050) in the subsequent Plan Year. Amounts above this carryover amount will be forfeited.

Funds may also be forfeited if you terminate your employment.

Dependent Care FSA

Dependent Care FSAs allow you to accumulate pre-tax funds to reimburse for qualified childcare expenses or day care expenses for a disabled or elderly/disabled dependent. If married, employees generally must have a working spouse to qualify for a Dependent Care FSA. Dependent Care FSAs are also subject to the "use it or lose it" rule. Expenses must be incurred in the plan year. Funds do not roll over to the next plan year and may be forfeited if you leave the company.

Dependent Care dollars become available as you contribute to the plan through payroll deductions.

Contribution Limits

The IRS sets the maximum dollar amount you can elect to contribute to an FSA Accounts.

- **Healthcare FSA:** The IRS limits the maximum contribution ($3,050 in 2023). Healthcare FSAs with a plan start date or renewal date on or after January 1, 2024, will be limited to this annual maximum contribution amount.
- **Dependent Care FSA:** The IRS limits the maximum annual contribution to $5,000 ($2,500 if married and filing separately). Other IRS restrictions may apply.

Changing Your Elections

The elections you make during open enrollment will remain in effect for the plan year. You may only change your election after open enrollment if you experience a qualifying life event (see page 1). Contact Human Resources if you think you have had a qualifying event and want to make a change.

Sterling Services

For more information, go to www.sterlingadministration.com, call us at 800-617-4729, or email us at benefits@sterlingadministration.com.

- **Personal customer service on the phone and via email Monday –** Friday
- Online access to your account at www.sterlingadministration.com

CLICK HERE to watch a video on Flexible Spending Accounts (FSA)

Employee Costs

2024 Medical	Monthly Premium	Teamsters, P&AE, Unrepresented		Police		Management, City Council, City Treasurer	
		City Portion	Employee Portion	City Portion	Employee Portion	City Portion	Employee Portion
Blue Shield Trio HMO							
Emp. Only	$770.18	$770.18	$0.00	$770.18	$0.00	$770.18	$0.00
Emp. +1 Dep	$1,417.12	$1,417.12	$0.00	$1,417.12	$0.00	$1,417.12	$0.00
Emp. +2/More	$1,925.44	$1,875.39	$50.05	$1,925.44	$0.00	$1,875.39	$50.05
Blue Shield Local Access+ *(SaveNet)* **HMO**							
Emp. Only	$935.30	$935.30	$0.00	$935.30	$0.00	$935.30	$0.00
Emp. +1 Dep	$1,719.56	$1,719.56	$0.00	$1,719.56	$0.00	$1,719.56	$0.00
Emp. +2/More	$2,651.60	$1,875.39	$776.21	$1,931.04	$720.56	$1,875.39	$776.21
Blue Shield Full HMO							
Emp. Only	$1,170.70	$1,170.70	$0.00	$1,170.70	$0.00	$1,170.70	$0.00
Emp. +1 Dep	$2,154.10	$1,875.39	$278.71	$1,931.04	$223.06	$1,875.39	$278.71
Emp. +2/More	$2,926.76	$1,875.39	$1,051.37	$1,931.04	$995.72	$1,875.39	$1,051.37
Blue Shield PPO							
Emp. Only	$1,545.12	$1,545.12	$0.00	$1,545.12	$0.00	$1,545.12	$0.00
Emp. +1 Dep	$2,843.04	$1,875.39	$967.65	$1,931.04	$912.00	$1,875.39	$967.65
Emp. +2/More	$3,862.80	$1,875.39	$1,987.41	$1,931.04	$1,931.76	$1,875.39	$1,987.41

Employee Costs (continued)

2024 Dental	Monthly Premium	Teamsters/P&AE		Police		Management, City Council, City Treasurer	
		City Portion	Employee Portion	City Portion	Employee Portion	City Portion	Employee Portion
Liberty Dental *(DHMO/Prepaid)*							
Emp. Only	$15.04	$15.04	$0.00	$15.04	$0.00	$15.04	$0.00
Emp. +1 Dep	$27.08	$27.08	$0.00	$27.08	$0.00	$27.08	$0.00
Emp. +2/More	$39.12	$39.12	$0.00	$39.12	$0.00	$39.12	$0.00
Ameritas Dental (PPO)							
Emp. Only	$50.32	$50.32	$0.00	$50.32	$0.00	$50.32	$0.00
Emp. +1 Dep	$100.12	$100.12	$0.00	$100.12	$0.00	$100.12	$0.00
Emp. +2/More	$176.64	$176.64	$0.00	$176.64	$0.00	$176.64	$0.00

2024 Vision	Monthly Premium	Teamsters/P&AE		Police		Management, City Council, City Treasurer	
		City Portion	Employee Portion	City Portion	Employee Portion	City Portion	Employee Portion
Ameritas - VSP Choice							
Emp. Only	$10.52	$0.00	$10.52	$0.00	$10.52	$10.52	$0.00
Emp. +1 Dep	$19.00	$0.00	$19.00	$0.00	$19.00	$19.00	$0.00
Emp. +2/More	$27.36	$0.00	$27.36	$0.00	$27.36	$27.36	$0.00
Ameritas - EyeMed							
Emp. Only	$8.60	$0.00	$8.60	$0.00	$8.60	$8.60	$0.00
Emp. +1 Dep	$15.96	$0.00	$15.96	$0.00	$15.96	$15.96	$0.00
Emp. +2/More	$23.36	$0.00	$23.36	$0.00	$23.36	$23.36	$0.00

CITY OF HERMOSA BEACH

2024 OPEN ENROLLMENT

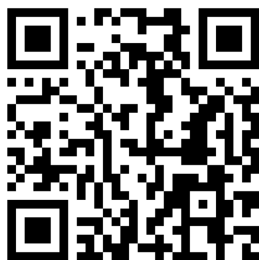
HOW DO I ENROLL?

A Building Blocks Benefit Advisor will assist you via a screen share enrollment which requires access to a computer and internet!

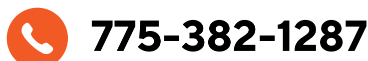
WHAT IS THE WELLCARD?

After completing your enrollment session with Building Blocks, you will receive complimentary membership to the WellCard Savings Program which has discounts on Medical, Pharmacy, Vision & Dental Care, Health & Wellness, Pet DIscounts, and more!

SCAN THE QR CODE TO SCHEDULE NOW!



CALL BUILDING BLOCKS TO SCHEDULE



775-382-1287

ACCIDENT

For a covered accident, policyholders receive cash benefits for use as they see fit.

CANCER

A plan designed to pay cash benefits that can be used to help offset cancer-related expenses.

CRITICAL ILLNESS

For a covered critical illness, policyholders receive a lump sum cash benefit to use as they see fit.

SHORT-TERM DISABILITY

In the case of illness or injury, it helps you maintain your standard of living, and helps you pay your bills.

HOSPITAL PROTECTION

Pays cash amounts to help with the non-covered expenses of a hospital stay.

LIFE INSURANCE

Helps you get the peace of mind knowing your family is taken care of.

FLEXIBLE SPENDING (FSA)

Allows you use pre-tax dollars to pay for eligible expenses for you, your spouse, and your dependents.

All products with this symbol have Guaranteed Issue available!

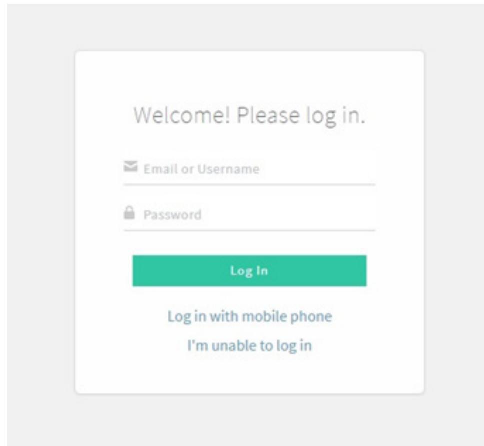
scheduling@bbforb.com

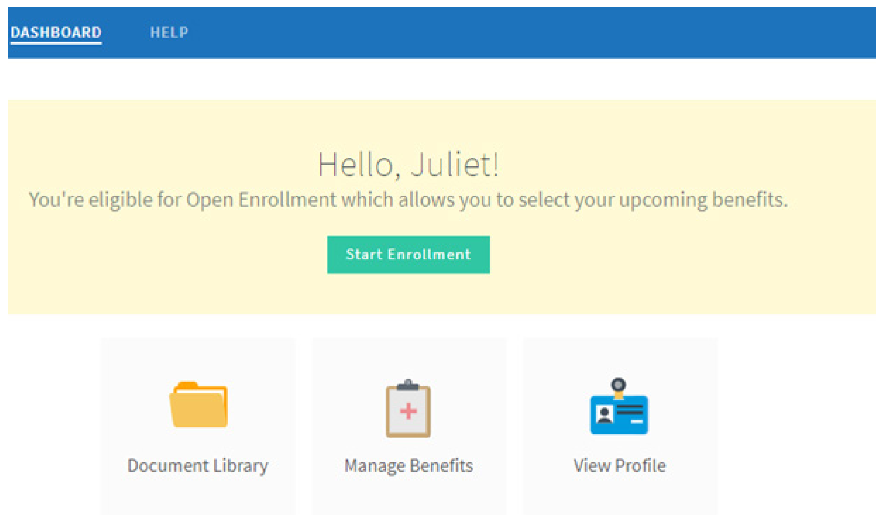
https://cityofhermosabeach.youcanbook.me

Ease Benefits Portal

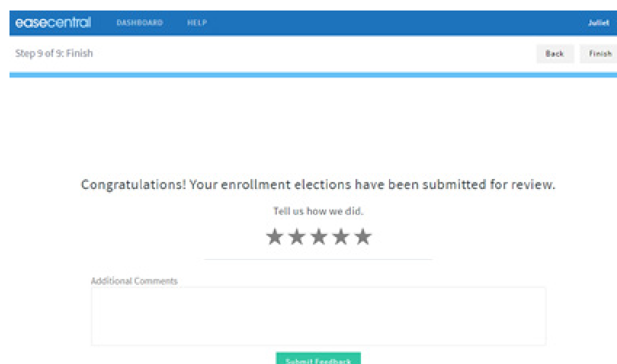
Ease Benefits Portal

You will be provided with login instructions to the Benefits portal during your appointment with the Benefit Advisor. You can access this portal all year long to reference the plan elections you made during enrollment, update personal and benefit information, view rates, plan summaries and all plan documents.





At the end of your appointment with your Benefit Advisory, you will have an opportunity to rate your experience.



Employee Discount & Rewards Center

Welcome to our Employee Discount & Rewards Center!

We provide a discount and perk program. With our Discount Center you can save on a variety of brands you love and earn cash back on many of your purchases.

Discounts

Enjoy discounts, rewards, and perks on thousands of the brands you love in a variety of categories:

- Travel
- Auto
- Electronics
- Apparel
- Local Deals
- Education
- Entertainment
- Restaurants
- Health and Wellness
- Beauty and Spa
- Tickets
- Sports and Outdoors

Signing Up is Easy!

1. **Visit our website at:** https://cityofhermosabeach.benefithub.com
2. **Enter Referral Code:** J59XTB
3. Register and Enjoy!

Questions?

Call 866-664-4621 or email customercare@benefithub.com

Cash Back

In addition to discounts, you can earn cash back on a variety of your purchases.

Simply find a deal with the Cash Back sign, redeem the offer and enjoy great savings plus cash back on that item and everything else you purchase from that store!

…and More!

Our Discount Center is constantly expanding to include more and more brands and deals. Stay updated by signing up for email notifications.

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.

Important Notices

No Surprises Act Notice

Our medical plans are subject to the No Surprises Act, which limits the amount covered persons may have to pay for some out-of-network surprise medical bills. More information about surprise billing requirements included under the No Surprises Act and similar state laws can be found on the medical insurance company's website or the Plan Sponsor's website. Additional information may be found in your Explanation of Benefits for any affected claims.

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for pregnancy hospital stay (for delivery) for a mother and her newborn 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 to this minimum length of stay. Early discharge is permitted only 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 Vanessa Godinez at (310) 318-0202.

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, contact the health plan using the number on your ID card.

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

You do not need prior authorization from the plan or any other person (including a primary care provider) 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 the health plan using the number on your ID card.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Blue Shield of California. 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 covered medical, dental, and vision plans (the "Plan"). **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified of a Qualifying Event:

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

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

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

NOTICE AND ELECTION PROCEDURES

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

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

Important Notices (continued)

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. (See Notice and Election Procedures.)

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

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

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

IF YOU HAVE QUESTIONS

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

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the 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 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.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including your spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

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

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

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

Vanessa Godinez
Human Resources Manager
(310) 318-0202

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 Hermosa Beach 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 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.**

- **Blue Shield of California has determined that the prescription drug coverage offered by City of Hermosa Beach 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 Hermosa Beach Blue Shield of California coverage will not be affected. If you keep this coverage and elect Medicare, the City of Hermosa Beach Blue Shield of California coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current City of Hermosa Beach Blue Shield of California 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 Hermosa Beach 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 the City of Hermosa Beach] changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

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

REMEMBER

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

Date: October 2023

Name of Entity / Sender: City of Hermosa Beach

Contact: Vanessa Godinez

Address: 1315 Valley Dr.
Hermosa Beach, CA 90254

Phone: (310) 318-0202

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

The City of Hermosa Beach 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 Vanessa Godinez at (310) 318-0202.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about The City of Hermosa Beach in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away.

Open Enrollment for health insurance coverage through Covered California will begin on November 1, 2023, and end on January 31, 2024. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com or KeenanDirect at 855-653-3626 or www.KeenanDirect.com.

Open Enrollment for most other states begins on November 1 and closes on January 15 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.healthcare.gov.

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 8.39% (for 2024) of your household income for the year, then that coverage for you is not Affordable. Affordability for dependent family members is determined separately and is based on the total cost of family coverage. 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. If you receive premium savings for Marketplace coverage, the IRS may seek reimbursement of those funds.

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.

STATES WITH INDIVIDUAL MANDATE

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Important Notices (continued)

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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. The information is numbered to correspond to the Marketplace application.

<table>
<tr><td>3. Employer name
City of Hermosa Beach</td><td colspan="2">4. Employer Identification Number (EIN)
95-6000720</td></tr>
<tr><td>5. Employer address
1315 Valley Dr.</td><td colspan="2">6. Employer phone number
(310) 318-0202</td></tr>
<tr><td>7. City
Hermosa Beach</td><td>8. State
CA</td><td>9. ZIP code
90254</td></tr>
<tr><td colspan="3">10. Who can we contact about employee health coverage at this job?
Vanessa Godinez, Human Resources Manager</td></tr>
<tr><td>11. Phone number (if different from above)</td><td colspan="2">12. Email address
vgodinez@hermosabeach.gov</td></tr>
</table>

As your employer, we offer coverage that meets the minimum value standard to the employees as described in this Guide. The coverage offered to you meets the minimum value standard and the cost of this coverage to you is intended to be affordable based on employee wages.

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

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

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. 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:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHIP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
800-221-3943 | TTY: Colorado relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
800-359-1991 | TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 855-692-6442

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

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp/
Phone: 678-564-1162, press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 800-457-4584IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888-346-9562

Important Notices (continued)

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 800-792-4884
HIPPA Phone: 800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 877-524-4718
Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 888-342-6207 (Medicaid hotline) or
855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_U
S
Phone: 800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 800-862-4840 | TTY: Massachusetts relay 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 800-657-3739

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

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

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov/
Medicaid Phone: 800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
HIPP Program Toll-Free Phone: 800-852-3345, ext. 5218

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

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

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

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
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
Phone: 800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855-697-4347 or 401-462-0311 (Direct RIte Share Line)

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

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

Important Notices (continued)

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
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: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid Phone: 800-432-5924
CHIP Phone: 800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-Free Phone: 855-MyWVHIPP (855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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

Contact Information

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

Plan	Plan Number	Phone Number	Web Site/Email
Medical			
• Blue Shield of California	W0002330	Refer to ID Card	blueshieldca.com
Dental			
• Liberty Dental HMO	Pending	888-703-6999	www.libertydentalplan.com
• Ameritas Fusion PPO	Pending	800-487-5553	www.ameritas.com
Vision			
• Ameritas - VSP	Pending	800-877-7195	www.vsp.com
• Ameritas - EyeMed	Pending	866-289-0614	www.eyemedvisioncare.com
Employee Assistance Program (EAP)			
• Holman Group	City of Hermosa Beach	800-321-2843	holmangroup.com **Username**: holmangroup **PW**: hb2285
Basic Life / AD&D, Optional Life, Long Term Disability (LTD)			
• Mutual of Omaha	Pending	800-877-5176	www.mutualofomaha.com
Flexible Spending Accounts (FSA) and COBRA			
• Sterling	N/A	800-617-4729	customer.service@sterlingadministration.com
Other Voluntary Insurance Products			
• Colonial/BB4B	N/A	775-382-1369	westservice@buildingblocksforbusiness.com
Benefits Consultant - Keenan & Associates			
• Kimberly Glesson	N/A	949-940-1760 ext. 5175	kglesson@keenan.com
• Andrea Estrin	N/A	949-940-1760 ext. 5133	aestrin@keenan.com
• Kelsey Marie White	N/A	949-940-1760 ext. 1123	kwhite@keenan.com

Glossary

Affordable Care Act and Patient Protection (ACA)

Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, covering preventive care without cost-sharing, etc, among other requirements.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Brand Name Drug

The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

The Consolidated Omnibus Budget Reconciliation Act allows people who lose their jobs to continue their employer-sponsored insurance coverage for up to 18 months.

Children's Health Insurance Program (CHIP)

The government program that provides free or low-cost health coverage for children up to age 19 in families whose income is too high to qualify for Medicaid but too low to afford private insurance. CHIP covers U.S. citizens and eligible immigrants. In some states, CHIP covers pregnant people. CHIP goes by different names in some states.

Claim

A request for payment that you or your health care provider submits to your health insurer to be paid or reimbursed for items or services you have received. Most often, you will not be responsible for making claim requests. Usually, billing and claims specialists employed by the health care provider (e.g. primary care office, hospital) will make the claim on your behalf.

Coinsurance

A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)

A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Comprehensive Coverage

A health insurance plan that covers the full range of care that you may need. This may include preventive services (like flu shots), physical exams, prescription drugs, and doctor or hospital care.

Deductible

The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Formulary

A list of prescription drugs covered by the health plan, often structured in tiers that subsidize low-cost generics at a higher percentage than more expensive brand-name or specialty drugs.

Generic Drug

Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)

High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

Glossary (continued)

Health Savings Account (HSA)

A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. State taxes may apply. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Health Reimbursement Arrangements (HRAs)

Unlike HSAs, only an employer may fund an HRA and the funds revert back to the employer when the employee leaves the organization. HRAs are not subject to the same contribution limits as HSAs, and they may be paired with either high-deductible plans or traditional health plans.

In-Network

Doctors, clinics, hospitals and other providers with whom the health plan has an agreement to care for its members. Health plans cover a greater share of the cost for in-network health providers than for providers who are out-of-network.

Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Out-of-Pocket Maximum

The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Out-Of-Network

A health plan may not cover treatment for doctors, clinics, hospitals and other providers who are out-of-network, but covered employees will pay more out-of-pocket to use out-of-network providers than for in-network providers.

Out-Of-Pocket Limit

The most an employee could pay during a coverage period (usually one year) for his or her share of the costs of covered services, including co-payments and co-insurance.

Plan Year

The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Preferred Provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount.

Premium

The amount that must be paid for a health insurance plan by covered employees, by their employer, or shared by both. A covered employee's share of the annual premium is generally paid periodically, such as monthly, and deducted from his or her paycheck.

Preventive Care

Health care services you receive when you are not sick or injured— so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

Qualifying Life Event

A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events include moving to a new state, certain changes in your income, and changes in your family size.

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

CLICK HERE to watch a video on Benefits Key Terms Explained