2024 BENEFITS

Wild, Wild, Wellness

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 Important Plan Information section for more details.

GETTING STARTED

2024 BENEFITS

January 1st, 2024
through
December 31, 2024

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, Tehama County supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

You are eligible if you are an employee working 20 or more hours per week.

Eligible dependents

- Legally married spouse.
- Domestic Partner is eligible for coverage if you have completed a Domestic Partner Affidavit
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the plan documents for each benefit.

Who is not eligible

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

- Parents, grandparents, and siblings.
- Any individual who is covered as an employee of Tehama County cannot also be covered as a dependent.
- Employees who work fewer than 20 hours per week, temporary employees, contract employees, or employees residing outside the United States.

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first of the month following 30 days. New hires who do not make an election within 31 days of becoming eligible will need to sign a waiver declining coverage

If you miss the enrollment deadline, you'll need to wait until the next open enrollment, the one time each year that you can make changes to your benefits for any reason.

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

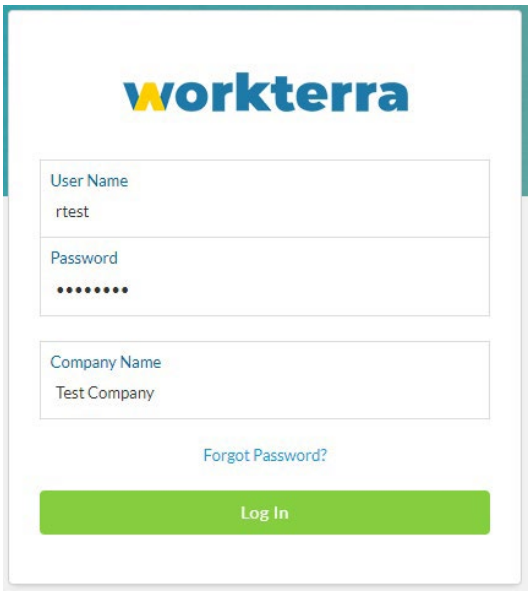
1. Any change you make must be consistent with the change in status.
2. You must make the change within 31 days of the date the event occurs.
3. All proper documentation is required to cover dependents(marriage certificates, birth certificates, etc.).

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act you have 60 days to request enrollment due to events allowed under CHIP.

Notify Personnel within 31 days if you have a qualifying life event and need to add or drop dependents outside of Open Enrollment.

ENROLLING FOR BENEFITS



MID YEAR CHANGES

- You have year-round access to a summary of your benefits through Workterra.
- Mid year changes should be initiated through Workterra - Personnel may reach out for additional verification.
- To begin a Qualifying Event (i.e. Marriage, Newborn, Divorce, etc.) click on the “Enroll Now” button found on the Home Page. If an event is not open, you will see an option to open a Qualifying Event by clicking “OK.”
- Then select the Qualifying Event that applies to you, enter the date of the event, and click “Save”. The system will now walk you through your personalized experience.

WORKTERRA

Workterra is an online system that enables you to make all your benefit decisions in one place. You can access Workterra from any computer with an internet connection. Our secure (https) site uses the latest technology to ensure that the information entered is secure and adheres to Workterra and industry security standards.

Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

Getting started

- LOG IN to Workterra.net

  Username: [first name, last name] Example: [janedoner]

  Note: if you wish to view the site in SPANISH, click on “Español (es-mx)” in the drop down box on the top right of the page.

  Password: must be a minimum of 8 characters.
- Password must contain at least one numeric digit.
- Password must contain at least one special character.
- Password must contain at least one UPPERCASE letter
- ADD your personal and dependent information.
- SELECT your benefit plans for the coming year.
- REVIEW your choices and costs before finalizing.
- After completing all of your plan elections, you will come to the Confirmation Statement. Please review all of your elections for accuracy.
- If you are having trouble logging into the site, Workterra Customer Service is here to help with password resets and site technical expertise. Customer Service is available Monday-Friday 8am-5pm Pacific Time 888-327-2770 or customerservice@workterra.com

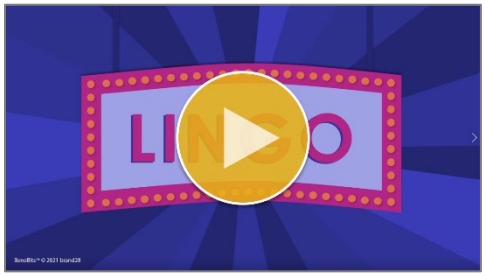
MEDICAL

OUR PLAN

Anthem Medical EPO

All About Medical Plans

Play the Health Lingo Game!



- Consider an EPO (Exclusive Provider Organization) if:
  - You want lower, predictable out-of-pocket costs
  - You like having one doctor to manage your care
  - You are happy with the selection of network providers
  - You don't see any doctors that are out-of-network
- **Plan To Consider**
  - Anthem Medical EPO

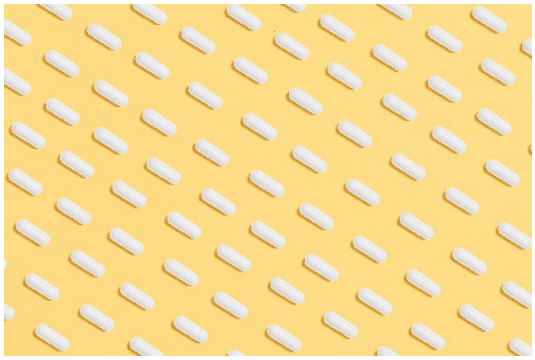
MEDICAL

You always pay the deductible and copayment ($). The coinsurance (%) the plan pays after the deductible.

	Anthem Medical EPO
	In-Network
Calendar Year Deductible[1] Individual Family Embedded	 $500 $1,500 Embedded
Calendar Year Out-of-Pocket Maximum[1,4] Individual Family Embedded	 $3,000 $9,000 Embedded
Office Visit Primary Care Specialist	 $15 Copay $15 Copay
LiveHealth Primary Care Specialist	 No Charge $15 Copay (Deductible Does Not Apply)
Preventive Services	No Charge
Chiropractic (up to 24 visits/year)	 90%[5]
Lab and X-ray	90%[5]
Urgent Care	$15 Copay
Emergency Room	$100 Copay 90%[5] (Copay Waived if Admitted)
Inpatient Hospitalization	90%[5]
Outpatient Surgery	90%[5]
PRESCRIPTION DRUGS- EXPRESS SCRIPTS	
Out-of-Pocket Maximum	$1000- Per Individual
Retail- 30 Day Supply Generics Preferred Brands Non-Preferred Brands Supply Limit	 $10 Copay $20 Copay $30 Copay 30 days
Mail Order- 90 Day Supply Generics Preferred Brands Non-Preferred Brands Supply Limit	 $20 Copay $30 Copay $45 Copay 90 Days

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year deductible January 1st through December 31st.
[2] An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.
[3]An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
[4]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[5]After deductible.

PRESCRIPTION DRUGS – EXPRESS SCRIPTS (ESI)



MANAGE YOUR MEDICATION. ANYTIME. ANYWHERE.

Online access to savings and convenience with express-scripts.com and the Express Scripts mobile app.

Contact Express Scripts Customer Service at (877) 733-4553.

Preferred Generic Program

Members who obtain a Brand drug when a Generic equivalent is available will be charged the difference between the Brand and the Generic plus the Generic co-pay. If members purchase the generic, they will only pay the generic co-pay in place.

Express Scripts Smart90 Program

This program allows members to obtain a 90-day supply of maintenance medications (those drugs you take regularly for ongoing conditions) at any Walgreens or CVS pharmacy. Members who fill their maintenance prescriptions with a 90-day supply at a preferred pharmacy could pay less for each 90-day supply than you would pay for three 30-day supplies at a non-preferred retail pharmacy. The Smart90 Program is offered alongside the Express Scripts Home Delivery Program.

Advantage Plus Pharmacy Utilization

This program is designed to provide optimal savings for employees. Members impacted by this program will receive communications directly from Express Script with instructions how to access their medications.

- **Prior Authorization** ensures clinically appropriate use of medications, ensures medications are used safely: Asks the question: “Is this the right medication for you.”
- **Step Therapy** encourages members and physicians to try clinically effective generic medications before trying the more expensive brand medications. Asks the question: “What other medications has the patient taken for this condition?”
- **Drug Quantity** aligns the quantity dispensed with FDA-approved dosage guidelines and other supportive evidence. Asks the question: “Is this the correct quantity (tablets/capsules) of this medication?”

SaveOnSP Specialty Rx Program

SaveOnSP helps to lower your out-of-pocket costs for over 250 specialty medications to $0. If you’re filling an eligible medication, a representative from SaveOnSP will contact you to discuss the program. If you choose not to participate, you’ll pay a higher copay when you fill your medication. Contact SaveOnSP today at (800) 683-1074 and identify that you are covered through PRISMHealth to determine if your specialty medication is eligible.

PRISM Value Added Services

Take advantage of these value added services available to PRISM plan members to help you get and stay healthy.

BENEFIT HIGHLIGHTS	AVAILABILITY & HOW TO GET STARTED
Physical Therapy for Back or Joint Pain **Hinge Health** Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy. Available for preventative, acute, and chronic needs at no cost.	*PPO & EPO members*[1] **Call:** (855) 902-2777 **Visit** hingehealth.com/prism/
Hip, Knee, and Spine Surgical Benefit and Breast Cancer Treatment Benefit **Carrum Health** Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel for patient and companion, and medical bills. Oncology benefit also available; guidance for all cancers; treatment for Breast Cancers.	*PPO & EPO members* **Visit** carrum.me/prisim
Diabetes Management Program **Livongo** No cost program to help members with diabetes reduce risk and improve condition management. Free meter and test strips using cellular real-time technology. Active monitoring and coaching also available.	*PPO & EPO members*[1] **Call:** (800) 945-4355 **Visit** welcome.livongo.com/prism

RESOURCES FOR ANTHEM MEMBERS

FINDING AN ANTHEM PROVIDER

To find a provider in the Anthem PPO network, please visit anthem.com/ca/prism/home.

ANTHEM ID CARDS

For PPO plans, one ID card will be issued to subscriber and one to spouse/domestic partner. Two cards will be issued in the subscriber's name for subscriber plus child(ren) contracts. ID cards with child dependent names can be requested by calling the member service number on the ID card. ID cards will be issued to each member enrolled. PPO/EPO enrollees will also receive an Express Scripts ID card to access pharmacy benefits.

Sydney Mobile App

Use Sydney™ Health to keep track of your health and benefits-all in one place. Access your plan details, Member Services, virtual care, and wellness resources. You can also set up an account at anthem.com/ca/register to access most of the same features from your computer.

Building Healthy Families

Building Healthy Families offers personalized, digital support through the Sydney℠ Health mobile app or on anthem.com/ca. This all-in-one program, at no extra cost to you, can help your family grow strong whether you're trying to conceive, expecting a child, or in the thick of raising young children.

Lark Diabetes Management Program

Available to participants at no cost. Track your progress, check in with your coach, and learn more about prediabetes right in Lark's free mobile app. This program follows guidelines from the Centers for Disease Control and Prevention (CDC) to help you make small changes that can improve your health and decrease your risk over time. Visit lark.com/anthemBC.

ConditionCare

ConditionCare is a disease management program available to members at no cost. The program provides tools, resources and support with Asthma (pediatric or adult), Chronic obstructive pulmonary disease (COPD), Coronary artery disease, Diabetes, types 1 and 2 (pediatric or adult) or Heart failure. For more details and/or to join, call the member services on your ID Card.

Livehealth Online

Visit with a board-certified doctor using your smartphone, tablet or computer with a webcam. Doctors are available 24/7 to assess your condition and, if it's needed, they can send a prescription to your local pharmacy. Register online at livehealthonline.com and download the mobile app.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Find out more

- FSA website
- Eligible Expenses – now include more over-the-counter items!
- Ineligible Expenses

DO YOU PAY FOR DEPENDENT CARE?

Look in the Financial Wellness page for information on tax savings through the Dependent Care FSA.

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through Workterra.

Here's how the FSA plan works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to $3,200, the 2024 annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.
- Expenses must be incurred between 01/01/24 and 12/13/2024 and claims must be submitted for reimbursement no later than 03/30/25. If you don't spend all the money in your account, Any additional remaining balance will be forfeited.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- You must re-enroll in this program each year.

FSA TAX SAVINGS EXAMPLE

$60,000 Annual Pay, with $1,500 FSA Contribution

$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings

$120,000 Annual Pay, with $2,750 FSA Contribution

$660 24% Federal income tax	**$210** 7.65% FICA tax	**$870** Annual FSA tax savings

Your tax savings may vary depending on tax filing status and other variables

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up to $5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by Workterra.

Here's how the Dependent Care FSA works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household per year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to $2,500 each year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Estimate carefully! You can’t change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

DENTAL

OUR PLAN

Delta Dental DPPO Plan PRISM

DID YOU KNOW?

Keeping your teeth and gums healthy isn't the only reason you should practice preventive dental care. With good dental hygiene, you can greatly reduce your risk of getting cavities, gingivitis, periodontitis, and other dental problems.

You can also reduce your risk of secondary problems caused by poor oral health such as diabetes, heart disease, osteoporosis, respiratory disease and even cancer.

Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers three types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures

DENTAL

You always pay the deductible and copayment ($). The coinsurance (%) shows what plan pays after the deductible.

	Delta Dental DPPO Plan PRISM	
	In-Network	**Out-of-Network**
Annual Deductible	$25 Per Individual $75 Per Family	$25 $75
Annual Plan Maximum	$1,700 Per Individual	$1,500 Per Individual
Waiting Period	12 Months for Major Services	In-Network Limitations Apply
Diagnostic & Preventive	100%	100%
Basic Services Fillings Root Canals Periodontics	 80% 80% 80%	 80% 80% 80%
Major Services	80%	80%
Orthodontia Adults Children	Not Covered	Not Covered

What you need to know about this plan

Features:	See any provider, but you'll pay more out of network
Am I restricted to in-network providers?	No
Do I have to select a primary dentist?	No
Can I use my HSA or FSA?	If you participate in a healthcare FSA you can use your account to pay for dental expenses.

VISION

OUR PLAN

VSP Vision Plan PRISM

Click to play video

Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

VISION

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	VSP Vision Plan PRISM	
	In-Network	**Out-of-Network**
Exams Benefit Materials Frequency	 $10 Copay $20 Copay Once every 12 months	 Up To $45 N/A In-network limitations apply
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	 Plan Pays 100% Plan Pays 100% Plan Pays 100% Once every 12 months	 Up to $30 Up to $50 Up to $65 In-network limitations apply
Frames Benefit Frequency	 $150 Allowance (20% Discount over allowance) Once every 24 months	 Up to $70 In-network limitations apply
Contacts (Elective) Conventional Frequency	 $130 Allowance (copay waived; instead of glasses) Once every 12 months	 Up to $105 (in-network limitations apply) In-network limitations apply

What you need to know about this plan

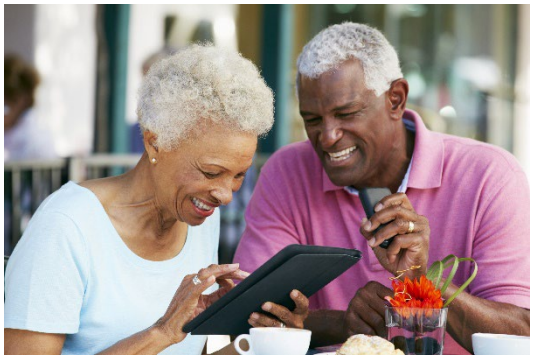
Features: See any provider, but you'll pay more out of network

What other services are covered? The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and even hearing aids.

Eyeglasses are expensive. Will I still be able to afford them, even with insurance? Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in a healthcare FSA you can use your account to pay for vision care and eyewear with tax-free dollars.

Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
Coverage with a retail chain may be different or not apply.

MOBILE RESOURCES



ACCESS YOUR BENEFITS ANYTIME, ANYWHERE

Most of our carriers and vendors have mobile apps available making accessing your benefits information easier than ever.

Just download the apps via the Apple App Store and Google Play and make sure to share with your dependents!

Download on the App Store

GET IT ON Google Play

Anthem Plan Members

- Meet Sydney, the mobile app that's all about you, your plan and your health care needs. It connects your questions to answers — and you to the right resources. Using it is like having a personal health assistant in the palm of your hand**.** .
- You get one-click access to benefits info, your member ID card and wellness resources. That means you can quickly find what you need.
- The more you use it, the more Sydney can help you stay healthy and save money. And Sydney's interactive chat feature can answer your questions in real time.
- Find care and check costs, view claims, see your benefits, view your ID card and more!

Delta Dental Plan Members

- Delta Dental subscribers can log in using the username and password they use to log in to our website. If you haven't registered, there is a link on the home screen to register for an account. If you've forgotten your username or password, you can also retrieve these via Delta Dental Mobile.
- You must enter your username and password each time you access the secure portion of the app. No personal health information is ever stored on your device. For more details on security, our Privacy Policy can be viewed via a link on the Login page of the app.

VSP Plan Members

- Find a doctor by name or location and get directions to your appointment.
- Access your Member Vision Card and personal benefit information.
- View Exclusive Member Extras, like rebates, special offers, and promotions.
- Get eye care information on a variety of topics to maintain optimal eye health.

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

COMPANY-PROVIDED LIFE AND AD&D INSURANCE

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by VOYA Financial and premiums are paid in full by Tehama County.

VOYA Financial Basic Life and AD&D

Class 1: Active Management, LEMA, DSA, Misc. Bargaining Unit Employees and Peace Officers' Bargaining Unit Employees	$30,000
Class 2: All Other Active Employees	$30,000
Class 3: All Other Retirees	$1,000
Class 4: Management and LEMA Retirees	$5,000
Class 5: Active Court Misc. Employees	$20,000

The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for details.

VOLUNTARY LIFE AND AD&D INSURANCE

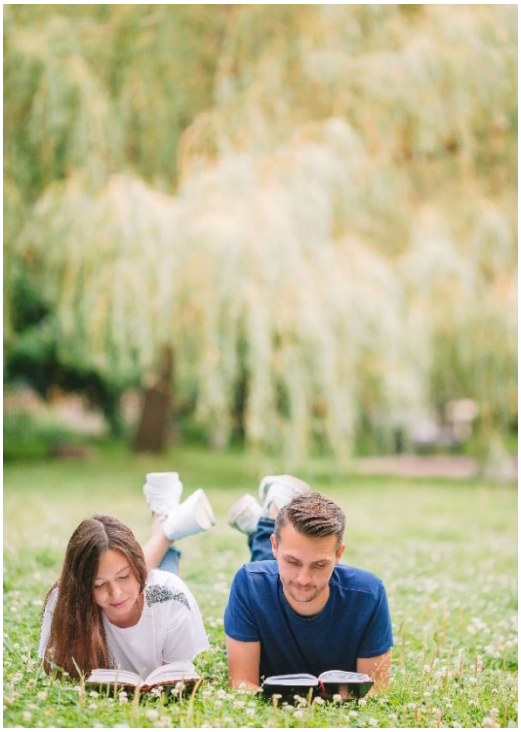
Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by VOYA Financial and available for your spouse and/or child(ren).

VOYA Financial Voluntary Life

Employee	Increments of Increments of $10,000 (minimum $20,000) up to Lesser of 5 x covered annual earnings or $500,000 Guaranteed Issue: $150,000
Spouse	Increments of Increments of $5,000 (minimum $10,000) up to $250,000 and not to exceed 50% of employee amount Guaranteed Issue: $50,000
Child(ren)	$10,000 Guaranteed Issue: $10,000

Note: Benefit amount reduces to 65% at age 65.



Evidence of Insurability (EOI)

If you select a coverage amount above a certain limit you will need to submit an Evidence of Insurability form with additional information about your health in order for the insurance company to approve this higher amount of coverage.

GUARANTEED ISSUE

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.

VOYA VALUE ADDED SERVICES

GET STARTED TODAY

To access these value added services, visit guidanceresources.com or download our mobile app "GuidanceNow" from your favorite app store.

ComPsych®

Telephonic clinical and work/life support, counseling visits, referrals for community services, free 30-minute financial and legal consultations, educational resources and webinars. Contact ComPsych Guidance Resources for more information at (877) 533-2363.

Estate Planning

EstateGuidance® makes it easy with online tools that walk you through the process in minutes. Just access the site using the directions provided and supply the information. Your will can be completed online and downloaded to your computer or printed and shipped to you.

Financial Resources

Just call your Guidance Resources toll-free number. You'll be connected to a Guidance Consultant who will talk with you about your specific situation and schedule a phone appointment for you with one of our financial experts.

Funeral Planning

Funeral planning and concierge services are provided by Everest Funeral Package, LLC, which offers both pre-planning and at-need services at or near the time of need. At-need services include price negotiation assistance and communicating the family's wishes to the funeral home. Contact an Everest Service Advisor at (800) 913-8318.

Travel Assistance

A comprehensive worldwide travel assistance program that includes pre-trip planning and emergency assistance to covered persons while traveling 100 miles or more from home. Call (800) 859-2821 or (202) 296-8355 for more info!

Legal Guidance

You'll be connected to a Guidance Consultant who will talk with you about your situation and schedule a phone appointment for you with one of our staff attorneys. If you need more immediate help, you can be connected to an attorney directly.

WELLBEING & BALANCE

THE KEY TO KEEPING YOUR BALANCE IS KNOWING WHEN YOU'VE LOST IT

The challenges of daily life can be hard to balance. Whether it’s work, school or family obligations, it’s no wonder that many of us sometimes have trouble managing the ups and downs of our day-to-day lives.

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it’s not always easy.

We offer an Employee Assistance Program (EAP) to help you manage stress, chemical dependency, mental health and family issues.

Taking care of yourself will help you be more effective in all areas of your life.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE EAP

Phone
(800) 932-0034
Website
Acispecialtybenefits.com

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through, ACI Specialty Benefits can help you handle a wide variety of personal issue such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; the program allows you and your family/household members up to 3 per incident per year.
- Unlimited web access to helpful articles, resources, and self-assessment tools

COUNSELING BENEFITS

- Difficulty with relationship
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

FINANCIAL COACHING

- Money management
- Debt management
- Identity theft resolution
- Tax issues

LEGAL CONSULTATION

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your benefit contributions
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify Tehama County if your domestic partner is your tax dependent.

COST OF COVERAGE-MONTHLY PREMIUMS

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

All Full Time Tehama County Employees

	EPO	PPO
Medical	$1,999.50	$2,475.50
Dental	$61.70	$61.70
Vision	$12.30	$12.30
Life ($30,000)	$5.58	$5.58
Total Premium	**$2,079.08**	**$2,555.08**
Less County Contribution	$1,853.66	$1,853.66
Employee Portion of full package	$225.42	$701.42
Employee Portion of life insurance purchased separately ($30,000)	$1.12*	$1.12*

*If you are a part-time employee you will pay a greater portion of the premium. Contact the Auditor's Office for the exact premium amount.
Please note that certain Court employees may have a different life insurance amount. Please contact your Personnel Office for clarification.

COST OF COVERAGE-CONTINUED-MONTHLY PREMIUMS

MEDICAL	EPO	PPO
Retiree only under 65	$1,999.50	$2,475.50
Retiree + Spouse both under age 65	$1,999.50	$2,475.50
Retiree + Spouse both under age 65 plus family	$1,999.50	$2,475.50
Retiree only, age 65 or older	$911.50	$1,198.50
Retiree + Spouse, both age 65 or older	$1,821.50	$2,393.50
Retiree (both 65+) and Family	$2,549.50	$3,204.50
Retiree + Spouse, one over & one under age 65 (one w/Medicare, one w/o Medicare)	$1,899.50	$2,549.50
Dental	$61.70	
Vision	$12.30	
Life Policy ($1,000)	$.20	$.20
Life Policy (5,000)	$1.00	$1.00

Retiree over 65 + Family contact workterra.

COBRA RATE-MONTHLY PREMIUMS

	EPO	PPO
Medical	$2,039.49	$2,525.01
Dental	$62.93	$62.93
Vision	$12.55	$12.55
Total Premium	**$2,114.97***	**$2,600.49***

*Premiums for COBRA include a 2% administration fee.

PLAN CONTACTS

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

Plan Type	Provider	Phone Number	Website
Medical	Anthem	(800) 967-3015	anthem.com/ca/prism
Prescription Drugs	Express Scripts	(877) 554-3091	express-scripts.com
Dental	Delta Dental	(800) 765-6003	deltadentalins.com
Vision	VSP	(800) 877-7195	vsp.com
Life and AD&D	VOYA	(800) 955-7736	voya.com
Employee Assistance Program	ACI Specialty Benefits	(800) 932-0034	acispecialtybenefits.com
FSA	Workterra	(888) 327-2770	workterra.com

IMPORTANT PLAN INFORMATION

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

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.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

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.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

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.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines 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.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

Medicare Part D Notice

Important Notice from Tehama County 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 Tehama County 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. Tehama County has determined that the prescription drug coverage offered by the Tehama County 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 Tehama County 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 Insert Name of Plan 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 Tehama County prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Tehama County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information [or call Personnel Office 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 Tehama County 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:	9/1/2023
Name of Entity/Sender:	Tehama County
Contact-Position/Office:	Personnel Office
Address:	727 Oak Street, Red Bluff, CA 96080
Phone Number:	(530) 527-4183

Women's Health and Cancer Rights Act

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. Therefore, the following deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call your plan administrator (530) 527-4183.

Newborns' and Mothers' Health Protection Act

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 at (530) 527-4183.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Tehama County's health 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 Tehama County's health 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 31 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 health plan enrollment within 31 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 31 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 Tehama County health 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 right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Tehama County describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting (530) 527-4183.

Michelle's Law

The Tehama County plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify Personnel Office in writing as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

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 July 31, 2023. 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)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program 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 (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

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: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov | KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 | Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 | 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: 1-800-862-4840 | TTY: 617-886-8102
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: 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 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/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://medicaid.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 or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
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
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

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
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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 of your modified adjusted household income.