

2019

Employee Benefits Overview



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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 page 24 for more details.



Your Next Wave Of Benefits Is Here.

At San Benito County, we believe that you, our employees, are our most important asset. Helping you and your families achieve and maintain good health—physical, emotional and financial—is the reason San Benito County offers you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts is provided at the back of this summary.

While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

The benefits in this summary are effective:

January 1, 2019 - December 31, 2019

2019 BENEFIT CHANGES

Plan	Benefit Changes
Anthem Choice PPO	Increased emergency room copay and calendar year deductible, see page 8
Anthem HDHP	<ul style="list-style-type: none"> - Increased calendar year deductible, see page 9 - NEW ID cards will be mailed - NEW Group and Bin Number (see page 21)
Anthem Safe PPO	Increased emergency room copay and calendar year deductible, see page 10
Life/Disability	New carrier: Voya, see page 13

Who Can You Cover?



married and/or living and working on their own.

- Over age 26 (23 for dental and vision) ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
- Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

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

WHO IS ELIGIBLE?

Employees in **regular, full-time positions and those appointed to a regular position at a time base of 50% or higher** are eligible for the benefits outlined in this overview.

In order to comply with the Affordable Care Act (ACA), San Benito County determines your eligibility for medical coverage based on the number of hours you work each month.

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

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit. Please review the affidavit carefully because it includes important information about the guidelines for adding, ending or changing your domestic partner. Any premiums for your domestic partner paid for by San Benito County are taxable income and will be included on your W-2. Any premiums you pay for your domestic partner will be deducted on an after-tax basis. Contact your tax advisor about your domestic partner's tax dependent status and advise San Benito County if your domestic partner is a tax dependent.
- Your children (including your Domestic Partner's Child):
 - Under the age of 26 (23 for dental and vision) are eligible to enroll in medical coverage. They do not have to live with you or be enrolled in school. They can be

WHO IS NOT ELIGIBLE?

Family 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 San Benito County cannot also be covered as a dependent.
- Employees who work less than 20 hours per week, temporary employees, contract employees, or employees residing outside the United States.

WHEN CAN I ENROLL?

Coverage for new employees begins on the **First of The Month Following Your Date of Hire**.

Open enrollment is generally held in October. Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

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

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

You have 31 days to make your change.

Cost of Medical, Dental and Vision

Plan by Tier	Monthly Premium	County Contribution	Employee Monthly Cost	Employee Bi-Weekly Cost
Kaiser HMO				
Single	\$794.00	\$550.00	\$244.00	\$122.00
Two Party	\$1,572.00	\$1,050.00	\$522.00	\$261.00
Family	\$2,040.00	\$1,315.00	\$725.00	\$362.50
Anthem Safety PPO				
Single	\$732.00	\$550.00	\$182.00	\$91.00
Two Party	\$1,465.00	\$1,050.00	\$415.00	\$207.50
Family	\$1,872.00	\$1,315.00	\$557.00	\$278.50
Anthem Choice PPO				
Single	\$837.00	\$550.00	\$287.00	\$143.50
Two Party	\$1,674.00	\$1,050.00	\$624.00	\$312.00
Family	\$2,176.00	\$1,315.00	\$861.00	\$460.50
Anthem HDHP				
Single	\$776.00	\$550.00	\$226.00	\$113.00
Two Party	\$1,551.00	\$1,050.00	\$501.00	\$250.50
Family	\$2,017.00	\$1,315.00	\$702.00	\$351.00

Delta Dental PPO	Monthly Premium	County Contribution	Employee Monthly Cost	Employee Bi-Weekly Cost
Single	\$45.20	\$30.00	\$15.20	\$7.60
Two Party	\$77.50	\$30.00	\$47.50	\$23.75
Family	\$126.60	\$30.00	\$96.60	\$48.30

MES Vision	Monthly Premium	County Contribution	Employee Monthly Cost	Employee Bi-Weekly Cost
Single	\$5.35	\$5.35	\$0.00	\$0.00
Two Party	\$10.70	\$5.35	\$5.35	\$2.68
Family	\$13.80	\$5.35	\$8.45	\$4.23

Getting Care When You Need It Now



WHEN TO USE THE ER

The emergency room shouldn't be your first choice unless there's a true emergency—a serious or life-threatening condition that requires immediate attention or treatment that is only available at a hospital.

WHEN TO USE URGENT CARE

Urgent care is for serious symptoms, pain, or conditions that require immediate medical attention but are not severe or life-threatening and do not require use of a hospital or ER. Urgent care conditions include, but are not limited to: earache, sore throat, rashes, sprains, flu, and fever up to 104°.

WHEN YOU NEED CARE NOW

What do you do when you need care right away, but it's not an emergency?

Kaiser Permanente Plan Participants

- Call Kaiser's 24/7 NurseLine at 800-464-4000
- Find an urgent care center by visiting kp.org
- Use Kaiser Video Visit (My Doctor Online) or schedule a telephone appointment

Anthem Medical Plan Participants

- Call Anthem's 24/7 NurseLine at 800-977-0027
- Find an urgent care center by visiting anthem.com/ca
- Use Anthem LiveHealth Online

GET A VIDEO HOUSE CALL

Kaiser and Anthem members can video chat with a doctor from the comfort of their own homes, without an appointment.

Kaiser's video visit is a secure and easy way to visit your doctor. It saves travel time and expense. All you need is a computer with a high-speed internet connection and a webcam or a smartphone mobile device. Visit kp.org/mydoctor/videovisits for more information.

Anthem's LiveHealth Online provides 24/7 access to U.S. board-certified physicians, copay is the same as your plan's office visit copay. Physicians can treat a host of common illnesses quickly and effectively through a real-time video visit. They can even send prescription orders to your local pharmacy. For more information, visit livehealthonline.com.

PREVENTIVE OR DIAGNOSTIC?

Preventive care is intended to prevent or detect illness before you notice any symptoms. Diagnostic care treats or diagnoses a problem after you have had symptoms.

Be sure to ask your doctor why a test or service is ordered. Many preventive services are covered at no out-of-pocket cost to you. The same test or service can be preventive, diagnostic, or routine care for a chronic health condition. Depending on why it's done, your share of the cost may change.

Whatever the reason, it's important to keep up with recommended health screenings to avoid more serious and costly health problems down the road.

Carrum Health

San Benito County has partnered with Carrum Health to provide eligible health plan members access to an **enhanced surgery benefit** program with top-quality hospitals and surgeons. Carrum Health is a special surgery benefit that provides exclusive access to Scripps Hospital, Stanford Health Care, Providence Saint John’s Health Center (Santa Monica), and The Hoag Orthopedic Institute’s Outpatient Center (Orange County).

Eligible members include active employees and their dependents who are enrolled in the Anthem PPO or High Deductible Health Plans. Eligible procedures include: hip and knee replacement, spinal fusion surgery, 80 orthopedic procedures (shoulder, elbow, wrist, hand, hip, knee, ankle, foot and spine), multiple spine procedures, coronary bypass (CABG), bariatric (weight loss) surgery. Please contact Carrum Health to learn if your desired procedure is available.

Use of this benefit is optional. This benefit is separate from and in addition to the benefits already provided under Anthem. This benefit is not administered by **Anthem**. This benefit must be accessed through Carrum Health.

Under the Carrum Health surgery benefit program, your personally assigned Carrum “Care Concierge” will:

- + Help complete forms
- + Gather and transfer medical records
- + Assist in the selection of a surgeon
- + Schedule the surgery
- + Make travel arrangements (if necessary)
- + Coordinate post-discharge recovery care



You will have special access to “Centers of Excellence” which are hospitals and surgeons that have been vetted for providing top-quality care and achieving better outcome!

Location	Procedures
SF Bay Area, CA	Hip and Knee Replacement Spinal Fusion Surgery
Santa Monica, CA	Hip and Knee Replacement
Orange County, CA	80 Orthopedic Procedures (Shoulder, Elbow, Wrist, Hand, Hip, Knee, Ankle, Foot and Spine)
San Diego, CA	Hip and Knee Replacement Multiple Spine Procedures Coronary Bypass (CABG) Bariatric (Weight Loss) Surgery

There are no medical bills! Co-insurance and deductibles will be waived!*

*Due to IRS regulations, on HDHP plans the deductible applies but the co-insurance is waived.

Travel expenses (if applicable) will be covered for the patient and an adult companion!

To learn more or get started with the program, contact Carrum Health
 Toll Free: 1-888-855-7806
 Online: carrum.me/EIAHEALTH

Medical

Medical coverage provides you with benefits that help keep you healthy like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

San Benito County gives you a choice of medical plans through Kaiser Permanente and Anthem Blue Cross.

Kaiser Permanente Traditional HMO Plan

In-Network

Calendar Year Deductible	
Individual	\$0
Family	\$0
Annual Out-of-Pocket Max	
Individual	\$1,500
Family	\$3,000
Lifetime Max	Unlimited
Office Visit	
Primary Provider	\$15 per visit
Specialist	\$15 per visit
Preventive Services	No Charge
Lab and X-ray	
CT, MRI, PET scans	No Charge
Other lab and x-ray tests	
Hospitalization	
Inpatient	No Charge
Outpatient	\$15 per surgery
Emergency Room	\$50 copay (waived if admitted)
Chiropractic and Acupuncture (20 visits per calendar year)	\$15 per visit
PRESCRIPTION DRUG	Generic Brand
Rx Copay Out of Pocket Max	Combined with Medical
Retail – 30 day supply	\$5 \$20
Mail Order – 90 day supply	\$10 \$40

Specific details and plan limitations are provided in the Summary Plan Description (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 summary differs from the Plan Documents, the Plan Documents will prevail.

Medical

Anthem Choice PPO

	In-Network	Out-of-Network
Calendar Year Deductible		
Individual		\$750
Family		\$1,500
Annual Out-of-Pocket Max		
Individual	\$3,000	N/A
Family	\$6,000	N/A
Lifetime Max	Unlimited	
Office Visit		
Primary Provider	\$20 per visit	40%
Specialist	\$20 per visit	40%
Preventive Services	No Charge	40%
Lab and X-ray		
CT, MRI, PET scans	20%	40%
Other lab and x-ray tests	20%	40%
Hospitalization		
Inpatient	20%	40%
Outpatient	20%	40%
Emergency Room	\$100 copay + 20% (copay waived if admitted)	
Outpatient Surgery	20%	40%, up to \$350 per visit
Chiropractic and Acupuncture (20 visits combined per calendar year)	\$15 per visit	40%
PRESCRIPTION DRUG		
Rx Copay Out-Of-Pocket Max	\$2,000 (individual) \$4,000 (family)	
	Retail	Mail Order
Generic	\$5	\$10
Preferred	\$20	\$40
Non-Preferred	\$50	\$100
Supply	31 days	90 days

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Medical

Anthem High Deductible Health Plan

	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	\$1,600	\$2,850
Family	\$3,200	\$8,550
Annual Out-of-Pocket Max		
Individual	\$4,000	\$8,000
Family	\$8,000	\$16,000
Lifetime Max	Unlimited	
Office Visit		
Primary Provider	\$25 per visit ²	30% ²
Specialist	\$25 per visit ²	30% ²
Preventive Services	No Charge	30% ²
Lab and X-ray		
CT, MRI, PET scans	\$25 per visit ²	30% ²
Other lab and x-ray tests	\$25 per visit ²	30% ²
Hospitalization		
Inpatient	\$250 per day (3 day Max) ²	30% ²
Outpatient	\$250 per day (3 day Max) ²	30% ²
Emergency Room	10% ²	
Outpatient Surgery	\$250/admission	30%, up to \$350 per visit
Chiropractic & Acupuncture Care (26 visits combined per calendar year)	10% ²	30% ²
PRESCRIPTION DRUG		
Rx Copay Out-Of-Pocket Max	Combined with medical	
	Retail	Mail Order
Generic	\$15 ²	\$30 ²
Preferred	\$25 ²	\$50 ²
Non-Preferred	\$35 ²	\$70 ²
Supply	30 days	90 days

¹HSA Compatible

²Benefit after plan deductible

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Medical

Anthem Safety PPO

	In-Network	Out-of-Network
Calendar Year Deductible		
Individual	\$550	\$850
Family	\$1,650	\$2,550
Annual Out-of-Pocket Max		
Individual	\$4,500	\$4,500
Family	\$9,000	\$9,000
Lifetime Max	Unlimited	
Office Visit		
Primary Provider	\$20 per visit	10%
Specialist	\$20 per visit	10%
Preventive Services	No Charge	No charge
Lab and X-ray		
CT, MRI, PET scans	10%	10%
Other lab and x-ray tests	10%	10%
Hospitalization		
Inpatient	10%	10%
Outpatient	10%	10%
Emergency Room	\$50 + 10% (copay waived if admitted)	
Outpatient Surgery	10%	10%, up to \$350 per visit
Chiropractic Care (20 visits per calendar year)	\$20 per visit	10%
Acupuncture Care	\$20 per visit	10%
PRESCRIPTION DRUG		
Rx Copay Out-Of-Pocket Max	\$2,650 (individual) \$5,300 (family)	
	Retail	Mail Order
Generic	\$10	\$20
Preferred	\$25	\$40
Non-Preferred	\$45	\$75
Supply	30 days	90 days

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Dental

County of San Benito provides you with a comprehensive coverage through Delta Dental.

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

Plan Benefits

Delta Dental

Calendar Year Maximum	In-Network	Out-of-Network
Per Member		\$1,500
Calendar Year Deductible		
Individual / Family	None	\$50 per individual
Deductible Waived for D&P	N/A	Yes
Diagnostic and Preventive		
Oral Exam		
X-Rays	100%	100%
Teeth Cleaning		
Basic Services		
Fillings		
Sealants		
Oral Surgery		
Periodontics (Gum disease)	80%	80%
Endodontics (Root Canal)		
Simple Tooth Extractions		
Major Services		
Crowns		
Inlays, Onlays	50%	50%
Cast Restorations		
Orthodontics	Adult & Child	
Benefit Percentage	60%	50%
Lifetime Maximum	\$1,500	\$1,500

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Vision

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions.

Vision plan through MES Vision is available to full-time employees only.

MES VISION

	In-Network	Non-Network
	Copay	Plan pays <u>up to:</u>
Exam	\$10	\$40
Material	\$25	See schedule below
Lenses		
Single	\$0 after copay	\$30
Bifocal	\$0 after copay	\$50
Trifocal	\$0 after copay	\$65
Contact Allowance (In lieu of Frames)	\$105 (Copay waived)	\$100
Frame Allowance	\$100 Allowance	\$40
Frequency of Services		
Eye Examination		12 months
Lenses		24 months
Frames		24 months
Contact Lenses (In lieu of Frames)		24 months

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Life and Disability Insurance

If you have loved ones who depend on your income for support, having life and accidental death and dismemberment (AD&D) insurance can help protect your family's financial security.

BASIC LIFE & AD&D INSURANCE

County pays for a **\$20,000** basic life insurance and AD&D policy for each employee.



VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Eligibility	All full-time employees of the employer working a minimum of 20 hours per week	
Employee Benefits		
Coverage Amount:	Choice of \$10,000 increments	
Minimum amount:	\$20,000	
Maximum amount:	\$500,000 , not to exceed 7x annual earnings	
Guarantee Issue:	\$250,000 , not to exceed 2x annual earnings	
Spouse Benefits		
Coverage Amount:	Choice of \$5,000 increments	
Minimum amount:	\$10,000	
Maximum amount:	\$250,000 , not to exceed 50% of employee benefit	
Guarantee Issue:	\$50,000	
Children Benefits		
Coverage Amount:	\$2,500, \$5,000, \$7,500 or \$10,000	
	Age	% of Original Benefit
Benefit Reduction Formula	65	65%
	70	40%
	75	25%

DISABILITY INSURANCE

General, Confidential and Management groups participate in the State Disability Insurance.

Employee Assistance Program (EAP)

Employee Assistance Program (EAP) is a FREE service to all County employees. Trindel Insurance Fund provides for confidential professional counseling to help employees and their family members resolve issues that affect their personal lives and/or work performance.

HOW TO START:

- Choose an EAP Provider from our EAP Provider List on Trindel's website: (trindel.org) under programs menu
- Make an appointment with an EAP Provider of your choice from our list. Take a copy of your most recent paystub or County badge to your first visit
- Contact Trindel Insurance Fund or your Loss Prevention Specialist if you have any questions
- You will receive up to three (3) sessions within any six (6) month period that may be used for the employee, their spouse and their dependent minor children as defined by the IRS



P.O. Box 2069

Weaverville, CA 96093

Phone: (530) 623-2322

Fax: (530) 623-5019

Email: office@trindel.org

Health Savings Account (HSA)

Only those enrolled in the Anthem High Deductible Health Plan are eligible to participate in an HSA. Please remember to re-elect your contributions each year. To enroll in the HSA, you will need to fill out the enrollment form called “Take Care Flex Benefits Plan Enrollment Form” by Wage Works.

Below are the inflation-adjusted HSA contribution limits for 2019:

	For 2018	For 2019	Change
HSA contribution limit (employer + employee)	Self Only: \$ 3,450 Family: \$ 6,900	Self Only: \$ 3,500 Family: \$ 7,000	Self Only: + \$50 Family: + \$100
HSA catch-up contributions (age 55 or older) ¹	\$1,000	\$1,000	No Change ²

¹ Catch-up contributions can be made any time during the year in which the HSA participant turns 55.

² Unlike other limits, the HSA catch-up contribution amount is not indexed; any increase would require statutory change



Flexible Spending Accounts

WHAT IS A FLEXIBLE SPENDING ACCOUNT (FSA)?

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend.

Healthcare Flexible Spending Account

This plan allows you to pay for eligible out-of-pocket healthcare expenses with pre-tax dollars. Eligible expenses include medical, dental, or vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. You may access your entire annual election from the first day of the plan year and you can set aside up to **\$2,700** this year.

IMPORTANT: Unused FSA money up to **\$500.00** will be carried over to the next plan year. Anything over \$500 will be forfeited.

Here are some examples of eligible medical expenses:

Eligible Medical Expenses:

- Amounts applied to insurance copayments, coinsurance, or deductibles for services received within the coverage period
- Chiropractic care
- Dental care, if for medical care (e.g., exams, cleanings, fillings, root canals, bridges, and dentures)
- Diagnostic services (e.g., X-rays, MRIs, and cancer screenings)
- Hearing devices (e.g., hearing aids and hearing aid batteries)
- Orthodontia (e.g., braces and retainers)
- Vision care (e.g., eye exams, prescription glasses/contact lenses, and contact lens solution)

Ineligible Expenses:

Expenses prohibited from reimbursement or not for medical care:

- Medical insurance premiums
- Long-term care services for chronically ill individuals
- Dietary supplements (including vitamins) taken for general health or well-being
- Elective cosmetic surgery/procedures
- Personal living expenses (e.g., food, clothing, furniture, mattresses, vacuums, hot tubs, etc.)
- Toiletries and personal care items (e.g., shampoo, deodorant, soap, toothbrushes, toothpaste, and skin moisturizers)

Limited Purpose Flexible Spending Account

A Limited Purpose FSA (LPFSA) is a flexible spending account that you may be able to enroll in when you have a health savings account (HSA). You can use an LPFSA to pay for eligible out-of-pocket dental and vision expenses. Such expenses include:

- Dental and orthodontia care; like fillings, X-rays and braces
- Vision care, including eyeglasses, contact lenses and LASIK surgery

Dependent Care Flexible Spending Account

This plan allows you to pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. Eligible expenses may include daycare centers, in-home child care, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are considered your tax dependent and are incapable of self-care. It is important to note that you can access money only after it is placed into your dependent care FSA account. You can set aside up to **\$5,000** per household for eligible dependent care expenses for the year.

Below are samples of eligible dependent care expenses:

- **Care outside the home:** Expenses incurred for services outside of your household for the care of a dependent (i.e., a baby sitter).
- **Dependent care center:** Expenses incurred for services provided by a dependent care center (i.e., a facility that complies with all applicable state and local laws and regulations, and that provides care for more than six individuals who do not reside at the facility).
- **Summer day camp:** Expenses incurred for a day camp that is primarily custodial in nature rather than educational.

Voluntary Benefits

The following voluntary insurance policies are available to San Benito County employees through Aflac:

Accident

- Emergency Treatment Benefit
- Specific-Sum Injuries Benefit
- Accidental-Death Benefit
- Initial Hospitalization Benefit
- Hospital Confinement Benefit

Cancer/Specified-Disease

- Initial Diagnosis Benefit
- Hospital Confinement Benefit
- Radiation and Chemotherapy Benefits
- Surgical/Anesthesia Benefit
- Benefits paid directly to the insured, unless otherwise assigned
- Benefits paid regardless of any other insurance
- Ambulance, Transportation, and Lodging Benefits
- Cancer Wellness Benefit

Critical Care and Recovery (Specified Health Event)

Pays a First-Occurrence Benefit, as well as Hospital Confinement and Continuing Care Benefits for heart attack, stroke, sudden cardiac arrest, coronary artery bypass surgery, end-stage renal failure, major human organ transplant, major third-degree burns, coma or paralysis.

Short-Term Disability

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

For more information about policy benefits, limitations, and exclusions, please call our Aflac insurance agent, Gregg Fiscalini, CA license number OJ20921, at **(408) 442-4446** or email gregg_fiscalini@us.aflac.com.



Other Benefits

DEFERRED COMPENSATION

Employees may participate in tax-deferred retirement savings. Two 457 plans available. Employees may rollover funds from prior 401k or 457 accounts. IRS limits apply.

RETIREMENT

Regular employees will be enrolled into the CalPERS retirement system in accordance with the Public Employees' Retirement Law. Employee contributions vary according to bargaining unit.

Employee Group	Contribution for Classic Employees	Contribution for PEPRA Employees
Miscellaneous (Non-safety) <i>(Participates in Social Security in addition to CalPERS)</i>	2% at 55	2% at 62
Safety <i>(Does not participate in Social Security)</i>	3% at 55	2.7% at 57

PAY DAY

Employees are bi-weekly. The insurance and benefits deductions will take place bi-monthly – normally the first two pay periods of the month. Bank/Credit union and 457 Retirement Deferrals deductions will take place bi-weekly.

VACATION

Based on continued years of service. Maximum accruals apply.

- < 4 years of service = 10 days per year
- 5 to 9 years of service = 15 days per year
- 10 to 14 years of service = 18 days per year
- 15 + years of service = 20 days per year

ADMINISTRATIVE LEAVE

Management employees receive 80 hours of administrative leave per calendar year. Forty (40) unused hours can be paid out at the end of the calendar year.

HOLIDAYS

13.5 holidays (including 3 floating) for most employees. Safety officers and dispatchers receive approximately 5% holiday pay in addition to their base pay in lieu of paid holidays off.

SICK LEAVE

15 days per year. Maximum accruals apply.

TUITION REIMBURSEMENT PROGRAM

Employees may be eligible for a \$750 tuition reimbursement per fiscal year for career related class(es) or training.

Other Benefits



MEMBERSHIP

County Federal Credit Union is a progressive, innovative, yet traditional financial institution. We are federally chartered credit union serving County and City employees, we are not open to the general public. With assets in excess of \$650 million and over 46,000 members, County Federal offers state-of-the-art delivery channels, multiple branch locations, Saturday hours and a wide selection of convenience oriented products and services. Highlights of our features and benefits include:

- ✓ Our FREE Rewards Checking account with no monthly service charge, no minimum balance requirement and no direct deposit requirement. Bill pay is also FREE.
- ✓ FREE 24-hour account access through services line Direct Connect 24, Online Banking, Mobile Banking and CO-OP ATM Network.CO-OP provides you with FREE access to over 30,000 ATM locations, including select 7-Eleven, Walgreens and Costco stores.
- ✓ Lower rates on consumer, credit card and mortgage loans. Second mortgage programs are also available.
- ✓ FREE access to our Car Connection Consultant who will take the hassle out of buying your next new or used vehicle, get you the best price possible and an APR discount on your next auto loan.
- ✓ FREE financial education and counseling through BALANCE, a division of Consumer Credit Counseling that works exclusively with credit unions.
- ✓ FREE seminars designed to help you plan for retirement, buy your first home, build a better budget and much more.
- ✓ The ability to sponsor your immediate family members for membership.
- ✓ Our M3 Money Club for children up to age 12 and Get Started Account for teens, ages 13-19. Financial Education and Scholarship opportunities are available to them as well.
- ✓ Membership for life! Once a member, you'll always be a member regardless of where you work or live in the future.
- ✓ Members can purchase U.S. Postage Stamps. Discount AMC and Cinemark movie tickets, discounted Disneyland and other amusement park tickets and See's candy gift certificates.

To establish your membership, simply visit one of their convenient branch locations and you may be able to have the \$5 one-time membership waived!



Meet Ben-IQ

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

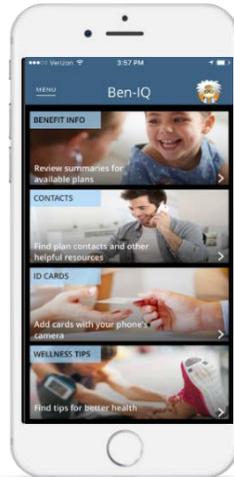
GETTING STARTED WITH BEN-IQ

1. Download and launch the app.
2. Enter your assigned Employer Key: **SanBenito**
3. Read and agree to the Terms and Conditions.



TAKE ADVANTAGE OF:

- ✓ **BENEFIT INFO**
Access to health plan highlights
- ✓ **FIND CONTACTS**
Find nurse line and other important contact numbers
- ✓ **ACCESS ID CARDS**
Store and organize plan ID cards
- ✓ **WELLNESS TIPS**
Wellness program information and tips



- ✓ **COST OF CARE**
Find out how much care should cost
- ✓ **MESSAGES**
Receive important messages from your HR/benefits team
- ✓ **VIDEOS**
Learn more about plan benefits with access to online videos
- ✓ **FAQ**
Access answers to frequently asked benefits questions

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

SMARTER IS BETTER

For Assistance

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

Plan Type	Group No./ID	Provider	Phone Number	Website
Medical	605299	Kaiser Permanente	(800) 464-4000	www.kp.org
Medical	Choice: 175075M750 Safety: 175075M754 HDHP: 175075M760, BIN: 020099	Anthem Blue Cross	(800) 967-3015	www.anthem.com/ca
Prescription (Anthem Only)	Same as Medical	Express Scripts	(877) 554-3091	www.express-scripts.com
Dental	1508-5555	Delta Dental	(800) 765-6003	www.deltadentalins.com
Vision	22142	MES Vision	(800) 877-6372	www.mesvision.com
Life and Disability	316407-189	Voya	(800) 955-7736	www.voya.com
Flexible Spending Account (FSA)		Wageworks	(877) 924-3967	www.wageworks.com
Employee Assistance Program (EAP)		Trindel Insurance Fund	(530) 623-2322	www.trindel.org
Credit Union		Santa Clara County Federal Credit Union	(408) 282-0700 (800) 282-6212	www.sccfcu.org
Benefits Administrator (medical)		Businessolver	(844) 427-5554	www.businessolver.com

Key Terms

MEDICAL/GENERAL TERMS

Allowable Charge - The most that an in-network provider can charge you for an office visit or service.

Balance Billing - Non-network providers are allowed to charge you more than the plan's allowable charge. This is called Balance Billing.

Coinsurance - The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70%, you are responsible for paying the remaining 30% of the cost.

Copay - The fee you pay to a provider at the time of service.

Deductible - The amount you have to pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).

Explanation of Benefits (EOB) - The statement you receive from the insurance carrier that explains how much the provider billed, how much the plan paid (if any) and how much you owe (if any). In general, you should not pay a bill from your provider until you have received and reviewed your EOB (except for copays).

Family Deductible - The maximum dollar amount any one family will pay out in individual deductibles in a year.

Individual Deductible - The dollar amount a member must pay each year before the plan will pay benefits for covered services. **In-Network** - Services received from providers (doctors, hospitals, etc.) who are a part of your health plan's network. In-network services generally cost you less than out-of-network services.

Out-of-Network - Services received from providers (doctors, hospitals, etc.) who are not a part of your health plan's network. Out-of-network services generally cost you more than in-network services. With some plans, such as HMOs and EPOs, out-of-network services are not covered.

Out-of-Pocket - Healthcare costs you pay using your own money, whether from your bank account, credit card, Health Reimbursement Account (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA).

Out-of-Pocket Maximum - The most you would pay out-of-pocket for covered services in a year. Once you reach your out-of-pocket maximum, the plan covers 100% of eligible expenses.

Preventive Care - A routine exam, usually yearly, that may include a physical exam, immunizations and tests for certain health conditions.

PRESCRIPTION DRUG TERMS

Brand Name Drug - A drug sold under its trademarked name. A generic version of the drug may be available.

Generic Drug - A drug that has the same active ingredients as a brand name drug, but is sold under a different name. Generics only become available after the patent expires on a brand name drug. For example, Tylenol is a brand name pain reliever commonly sold under its generic name, Acetaminophen.

Dispense as Written (DAW) - A prescription that does not allow for substitution of an equivalent generic or similar brand drug.

Maintenance Medications - Medications taken on a regular basis for an ongoing condition such as high cholesterol, high blood pressure, asthma, etc. Oral contraceptives are also considered a maintenance medication.

Non-Preferred Brand Drug - A brand name drug for which alternatives are available from either the plan's preferred brand drug or generic drug list. There is generally a higher copayment for a non-preferred brand drug.

Preferred Brand Drug - A brand name drug that the plan has selected for its preferred drug list. Preferred drugs are generally chosen based on a combination of clinical effectiveness and cost.

Specialty Pharmacy - Provides special drugs for complex conditions such as multiple sclerosis, cancer and HIV/AIDS.

Step Therapy - The practice of starting to treat a medical condition with the most cost effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

DENTAL TERMS

Basic Services - Generally include coverage for fillings and oral surgery.

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

Endodontics - Commonly known as root canal therapy.

Implants - An artificial tooth root that is surgically placed into your jaw to hold a replacement tooth or bridge. Many dental plans do not cover implants.

Major Services - Generally include restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Orthodontia - Some dental plans offer Orthodontia services for children (and sometimes adults too) to treat alignment of the teeth. Orthodontia services are typically limited to a lifetime maximum.

Periodontics - Diagnosis and treatment of gum disease.

Pre-Treatment Estimate - An estimate of how much the plan will pay for treatment. A pre-treatment estimate is not a guarantee of payment.

Important Plan Notices and Documents

Medicare Part D Notice

Important Notice from County of San Benito 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 County of San Benito 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. County of San Benito has determined that the prescription drug coverage offered by the Kaiser Permanente & Anthem Blue Cross are, 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 County of San Benito coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **Important Note for Retiree Plans:** Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

Since the existing prescription drug coverage under Kaiser and Anthem are 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 County of San Benito 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 County of San Benito and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. [NOTE: You'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 County of San Benito changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2019
Name of Entity/Sender:	County of San Benito
Contact-Position/Office:	Elvia Barocio, Human Resources Analyst
Address:	481 Fourth Street, Hollister, CA 95023
Phone Number:	(831) 636-4000 extension 14

CMS Form 10182-CC Updated April 1, 2011 According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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. If you would like more information on WHCRA benefits, call your Human Resources.

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 Human Resources.

NOTICE OF CHOICE OF PROVIDERS

The HMO plans generally allows 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, HMO plans 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 carriers directly.

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

You do not need prior authorization from the plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your medical carrier directly.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment County's 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 the County's plans 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 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 after the loss of other coverage.
- Gain a new dependent as a result of marriage, 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 the County's medical plans 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.

MICHELLE'S LAW

The 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 Human Resources 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 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 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 askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

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

ALABAMA – Medicaid

Website: <http://www.myalhipp.com>

Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: <http://myakhipp.com/>

Phone: 1-866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility:

<http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/>

Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO – Medicaid

Health First Colorado Website:

<https://www.healthfirstcolorado.com/>

Health First Colorado Member Contact Center:

1-800-221-3943/ State Relay 711

CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus

CHP+ Customer Service: 1-800-359-1991/

State Relay 711

FLORIDA – Medicaid

Website: <http://flmedicaidtprecovery.com/hipp/>

Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: <http://dch.georgia.gov/medicaid>

- Click on Health Insurance Premium Payment (HIPP)

Phone: 404-656-4507

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64

Website: <http://www.in.gov/fssa/hip/>

Phone: 1-877-438-4479

All other Medicaid

Website: <http://www.indianamedicaid.com>

Phone 1-800-403-0864

IOWA – Medicaid

Website: <http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp>

Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <http://www.kdheks.gov/hcf/>

Phone: 1-785-296-3512

KENTUCKY – Medicaid

Website: <http://chfs.ky.gov/dms/default.htm>
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: <http://dhh.louisiana.gov/index.cfm/subhome/1/n/331>
Phone: 1-888-695-2447

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

Website: <http://www.mass.gov/MassHealth>
Phone: 1-800-462-1120

MINNESOTA – Medicaid

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

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
Phone: 1-855-632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

NEVADA – Medicaid

Medicaid Website: <http://dwss.nv.gov/>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <http://www.dhhs.nh.gov/oii/documents/hipppapp.pdf>
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website:

<http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Medicaid Phone: 609-631-2392

CHIP Website:

<http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website:

http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://dma.ncdhhs.gov/>

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website:

<http://www.nd.gov/dhs/services/medicalserv/medical/>
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid

Website:

<http://healthcare.oregon.gov/Pages/index.aspx>
<http://www.oregonhealthcare.gov/index-es.html>
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website:

<http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm>
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: www.eohhs.ri.gov/

Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

Website: <http://www.scdhhs.gov>

Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: <http://dss.sd.gov>

Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <https://www.gethipptexas.com/>

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Website: <https://medicaid.utah.gov/>

CHIP Website: <http://health.utah.gov/chip>

Phone: 1-877-543-7669

VERMONT – Medicaid

Website: <http://www.greenmountaincare.org/>

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website:

http://www.coverva.org/programs_premium_assistance.cfm

Medicaid Phone: 1-800-432-5924

CHIP Website:

http://www.coverva.org/programs_premium_assistance.cfm

CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program>

Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: <http://mywvhipp.com/>

Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:

<https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://wyequalitycare.acs-inc.com/>

Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

OMB Control Number 1210-0137

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)



Rev. 10/1/2018