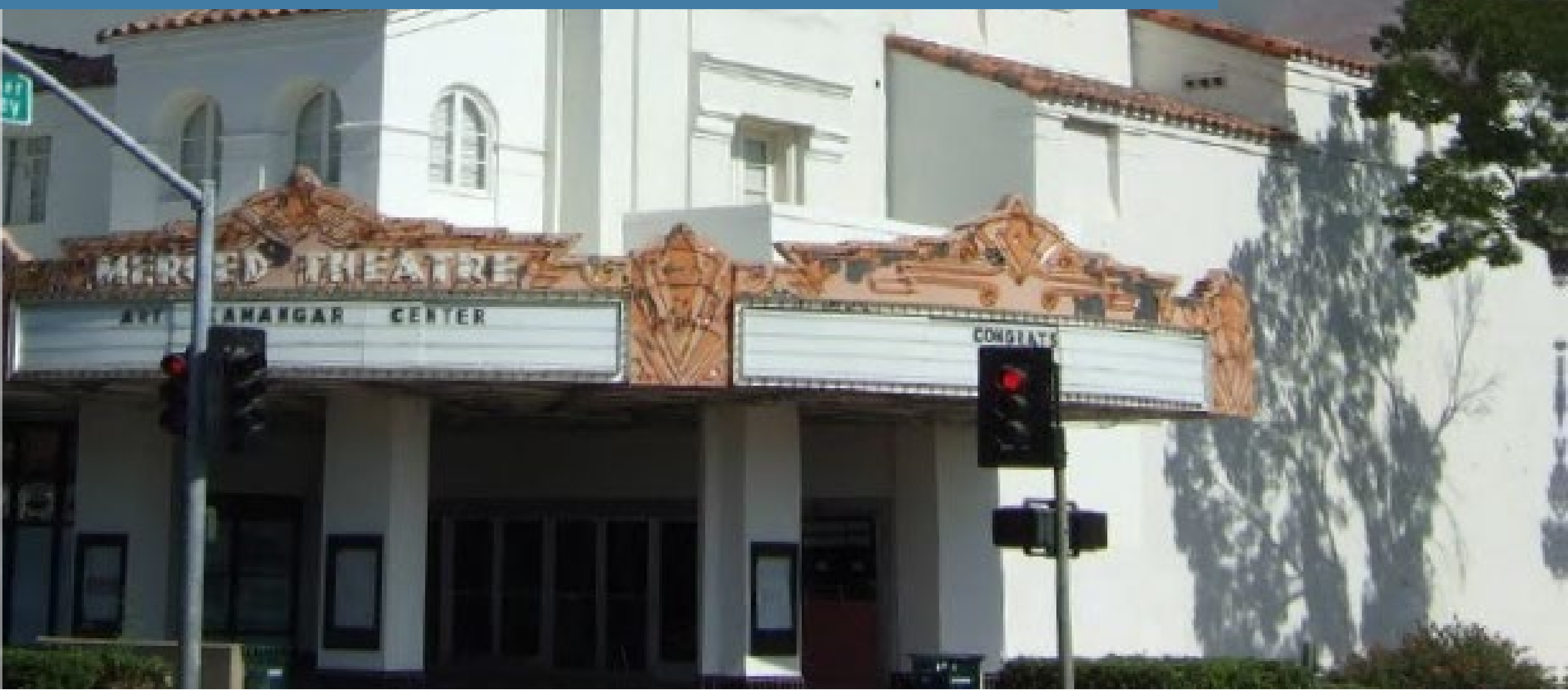
2024 Employee Benefits Guide

City of Merced



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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 the Important Plan Information section for more details.

GETTING STARTED

2024 CITY OF MERCED BENEFITS

January 1, 2024
through
December 31, 2024

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, City of Merced 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 a full-time employee. Employees with variable hours and seasonal schedules may be considered eligible for benefits. Refer to "Determining Eligibility" later in this guide for details.

Eligible dependents

- Legally married spouse.
- Registered Domestic Partner (RDP), where applicable by state law, 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 benefit booklets for each benefit.

Who is not eligible

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

- Parents, grandparents, and siblings.
- Employees who work less than 30 hours per week, temporary employees not on City of Merced payroll, contract employees, or employees residing outside the United States.

When you can enroll

Medical coverage for new employees begins upon your date of hire. Dental and vision coverage begins on the first day of your seventh month.

Open enrollment for employees is generally held in October of each year. Open enrollment is the only 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 have a qualifying life event and need to make a change (add or drop) to your coverage election.

Qualifying Life Events include (but are not limited to):

- Birth or adoption of a baby or child (31 days)
- Loss of other healthcare coverage (31 days)
- Marriage/Domestic Partnership (31 days)
- Divorce/Termination of Domestic Partnership (31 days)

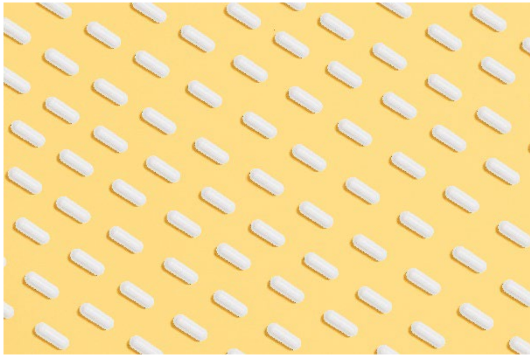
Please refer to Important Plan Notices on page 22 for further information.

Medical – Anthem Blue Cross

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

	Anthem Blue Cross	
	Core Plan	**Buy-Up Plan**
	In-Network Only	In-Network Only
Calendar Year Deductible1 Individual Family	$100 per Individual $300 per Family	None
Calendar Year Out-of-Pocket Max Individual Family	$1,600 per Individual $3,300 per Family	$1,000 per Individual $2,000 per Family
Office Visit Primary Care Specialist	$20 copay $20 copay	$10 copay $10 copay
Preventive Services	Plan pays 100%	Plan pays 100%
Chiropractic (up to 30 visits/year)	$5 copay	$5 copay
Lab and X-ray	Plan pays 100% after deductible	Plan pays 100% after deductible
Urgent Care	$20 copay	$10 copay
Emergency Room	$200 copay per visit (copay waived if admitted)	$100 copay per visit (copay waived if admitted)
Inpatient Hospitalization	$100 per day for the 1st three days (per occurrence)	Plan pays 100%
Outpatient Surgery	$100 per admit	Plan pays 100%
PRESCRIPTION DRUGS - Express Scripts (ESI)		
Calendar Year Deductible	None	None
Out-of-Pocket Maximum	$5,000 per Individual $9,900 per Family	$5,600 per Individual $11,200 per Family
Retail- 30 Day Supply Generic Preferred Brand Non Preferred Brand	$7 copay $25 copay Member pays 100% of ESI discounted price	$10 copay $20 copay Member pays 100% of ESI discounted price
Mail Order- 90 Day Supply Generic Preferred Brand Non Preferred Brand	$14 copay $60 copay Member pays 100% of ESI discounted price	$20 copay $40 copay Member pays 100% of ESI discounted price

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.

ExpressScriptsSmart90 Program

This program allows members to obtain a 90-day supply of maintenance medications at any Walgreens or CVS pharmacy. Members who fill their maintenance prescriptions with a 90-day supply save money. The Smart90 Program is offered alongside the Express Scripts Mail Order Pharmacy Program and is not a replacement of the existing Mail Order 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.

RESOURCES FOR ANTHEM MEMBERS

FINDING AN ANTHEM PROVIDER

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

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.

Lark Diabetes Prevention Program

Available to participants of Anthem Blue Cross 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.

Livongo Diabetes Management Program

Available to participants of Anthem Blue Cross at no cost. This program helps 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. Visit welcome.livongo.com/prism to get started.

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. Psychiatry and Psychology services are also available. Register online and download the mobile app.

CARRUM HEALTH SURGERY BENEFIT

Click to play video

WHERE CAN I GET MORE INFO?

Phone: 1-888-855-7806

Web: carrum.me/prism

Mobile App: Search Carrum Health in the App Story or Google Play to download the app!

A surgery benefit that's hard to believe

When it comes to surgery or major medical treatment, you need to know you're getting the best care. That's why City of Merced is sponsoring Carrum Health as a benefit to all Carrum Health members. Carrum makes it easier, more enjoyable, and less expensive to get high-quality healthcare.

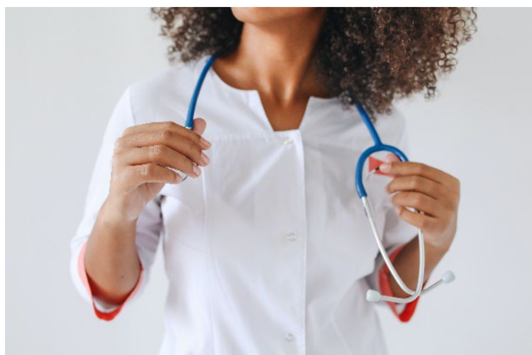
Covered surgeries include:

- Knee
- Hip
- Elbow
- Oncology
- Spine
- Shoulder
- Cardiac (heart)
- Bariatric (weight loss)

How it works

- **Activate your account**
  Answer a few questions about your health history, read profiles of surgeons, and get a detailed estimate of out-of-pocket costs, if any.
- **Meet your care specialist virtually**
  A dedicated care specialist will reach out to walk you through the process, learn about you and your goals, and answer all of your questions.
- **Relax as Carrum plans your surgery**
  Your care specialist will gather your medical records, submit forms to your surgeon, and plan travel for you and your loved one, if necessary. You'll also meet with your surgeon in person or virtually to ensure surgery is absolutely medically necessary.
- **Receive world-class care**
  You'll be in the best hands on the day of your surgery and walk away feeling stronger and healthier.
- **Never get a medical bill**
  The Carrum Health benefit covers all of the medical costs related to your procedure, so you won't have any surprise bills.

PREVENTIVE CARE SCREENING BENEFITS



TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit cdc.gov/prevention for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

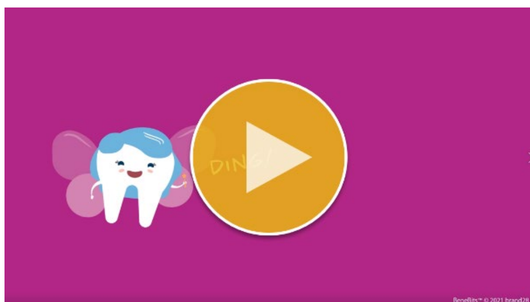
DENTAL

OUR PLANS

Delta Dental Core Plan

Delta Dental Buy-Up Plan

Click to play video



We offer 2 dental plans through Delta.

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 four 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
- **Orthodontia** treatment to properly align teeth within the mouth.

There are no ID cards necessary for this plan.

Dental – Delta Dental

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

	Delta Dental Core PPO		Delta Dental Buy-Up PPO	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	None	$25 per Individual $75 per Family	None	$25 per Individual $75 per Family
Annual Plan Maximum	$1,500 per Individual	$1,500 per Individual	$2,000 per Individual	$2,000 per Individual
Diagnostic & Preventive	Plan pays 100%	Plan pays 100% of UCR	Plan pays 100%	Plan pays 100% of UCR
Basic Services Fillings Root Canals Periodontics	Plan pays 100%	Plan pays 100% of UCR	Plan pays 100%	Plan pays 100% of UCR
Major Services	Plan pays 100%	Plan pays 100% of UCR	Plan pays 100%	Plan pays 100% of UCR
Orthodontia Adults Children (up to age 19)	Plan pays 100%	Plan pays 100% of UCR	Plan pays 100%	Plan pays 100% of UCR
Ortho Lifetime Max	$1,000	$1,000	$1,500	$1,500

UCR: Usual, Customary, Reasonable – Fees paid according to geographic location

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 FSA? If you participate in a healthcare FSA, you can use your account to pay for dental expenses.

VISION

OUR PLANS

VSP Choice Core Plan

VSP Choice Buy-Up Plan

Click to play video

We offer 2 vision plans through VSP.

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.

VSP provides participants with access to a large network of vision care providers. To locate a network provider visit www.vsp.com. If you decide not to see a VSP doctor, the plan co-pay still applies. This choice is yours— either way, your VSP benefits are a tremendous part of your overall benefits package. There are no ID cards necessary for this plan

Vision – VSP Choice Plans

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 Choice Core Plan	
	In-Network	**Out-of-Network**
Exams Benefit Frequency	 $25 copay Once every 12 months	 Plan pays up to $45 Once every 12 months
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	 $25 copay $25 copay $25 copay Once every 12 months	 Plan pays up to $30 Plan pays up to $50 Plan pays up to $65 Once every 12 months
Frames Benefit Frequency	 $120 Allowance + 20% off the amount over Once every 24 months	 Plan pays up to $70 Once every 24 months
Contacts (Elective) Conventional Frequency	 $120 Allowance Once every 24 months in lieu of eyeglasses	 Plan pays up to $105 Once every 24 months in lieu of eyeglasses

	VSP Choice Buy-Up Plan	
	In-Network	**Out-of-Network**
Exams Benefit Frequency	 $25 copay Once every 12 months	 Plan pays up to $45 Once every 12 months
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	 $25 copay $25 copay $25 copay Once every 12 months	 Plan pays up to $30 Plan pays up to $50 Plan pays up to $65 Once every 12 months
Frames Benefit Frequency	 $120 Allowance + 20% off the amount over Once every 12 months	 Plan pays up to $70 Once every 12 months
Contacts (Elective) Conventional Frequency	 $120 Allowance Once every 12 months in lieu of eyeglasses	 Plan pays up to $105 Once every 12 months in lieu of eyeglasses

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.

We provide short and long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

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.

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 and premiums are paid in full by City of Merced.

Voya Basic Life and AD&D (Core Benefit)

Basic Life Amount	1 x covered annual earnings up to a maximum of $50,000
Basic AD&D Amount	1 x covered annual earnings up to a maximum of $50,000
Guarantee Issue Amount	1 x covered annual earnings up to a maximum of $50,000

Supplemental Life and AD&D (Buy-Up Options)

Employee Benefit:

Buy-Up Life Amount	5 x covered annual earnings up to a maximum of $100,000
Election Options	$10,000; $20,000; $40,000; $50,000; $60,000; $80,000; $100,000
Guarantee Issue Amount	$100,000
Employees over Age 70	Maximum benefit is $50,000

Spouse Benefit:

Buy-Up Life Amount	Up to $50,000
Election Options	$5,000; $10,000; $20,000; $30,000; $40,000; $50,000
Guarantee Issue Amount	$50,000

Dependent Child(ren) Benefit:

Birth to 14 Days	$0
14 Days to 6 Months	$250 (14 Days to 6 Months)
6 Months to 26 Years	$10,000
Guarantee Issue Amount	$10,000

A NOTE ABOUT TAXES

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

IMPORTANT:

The Core Benefit is only for the term of employment.

The Buy-Up option is for employees to take with them and continue to pay the premium to have once leaving the City of Merced

SHORT-TERM DISABILITY INSURANCE (STD)

EXPECT THE UNEXPECTED

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

SUBMITTING A CLAIM

If you are disabled due to an illness or accidental injury, unable to work, and under the care of a licensed physician, you are eligible to submit a claim for benefits under this plan. As long as you remain disabled and meet the plan's disability requirements, you will continue to receive a percentage of your earnings until benefits are no longer payable.

The City of Merced offers an integrated disability plan that is designed to be simpler and more cost effective for employees. This feature includes a Short-Term Disability plan which allows for weekly payments during your initial disability period up to 22 weeks (180 days), after a 30 day waiting period. If your disability exceeds 22 weeks (180 days), your payments will convert to a Long-Term Disability plan and you will receive monthly payments for the duration of your disability per contract definitions. If you continue to be disabled, you are automatically assigned a Long-Term Disability benefit. Coverage is provided by Voya.

	Core Benefit	Buy-Up Option
Weekly Benefit Amount:	Plan pays 60% of covered monthly earnings	Plan pays 66.67% of covered monthly earnings
Maximum Weekly Benefit:	$600/week	$1,650/week
***Benefits Waiting Period:**	30 Days of Disability	30 Days of Disability
****Maximum Payment Period:***	22 Weeks	22 Weeks

*Maximum payment period is based on the first day you are disabled.

Core Disability Benefits:

- The Short-Term Disability plan starts after 30 days of disability and pays a weekly benefit of 60% of your weekly salary to a maximum of $600 a week. The duration of the Short Term Disability benefit is 22 weeks (180 days), minus the elimination period.

Buy-Up Disability Benefits: As an employee, you will also have the opportunity to purchase additional benefits.

- STD Buy-up to 66.67% of your weekly salary to a maximum of $1,650 a week. The duration of the Short Term Disability benefit is 22 weeks (180 days), minus the elimination period and exhaustion of leave accruals.

LONG-TERM DISABILITY INSURANCE (LTD)

4 THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.
4. Benefits are tax-free, since you pay the premiums with after-tax dollars.

LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

	Core Benefit	Buy-Up Option
Monthly Benefit Amount	Plan pays 60% of covered monthly earnings	Plan pays 66.67% of covered monthly earnings
Maximum Monthly Benefit	$2,500/month	$7,000/month
Benefits Waiting Period:	180 Days of Disability	180 Days of Disability
Maximum Payment Period	To age 65 or SSNRA	To age 65 or SSNRA

Core Disability Benefits:

- The Long-Term Disability benefit is paid on a monthly basis and covers up to 60% of your monthly salary up to a maximum of $2,500 a month. The duration of the Long Term Disability benefit is to age 65 or your normal social security retirement age as long as you meet the definition of disability..

Buy-Up Disability Benefits: As an employee, you will also have the opportunity to purchase additional benefits.

- Buy-up to 66.67% of your monthly salary up to a maximum of $7,000 a month. The duration of the Long Term Disability benefit is to age 65 or your normal social security retirement age as long as you meet the definition of disability.

Disability Insurance-Firefighters

The City of Merced's Firefighters group disability benefit is provided by the California Association of Professional Firefighters (CAPF). Disability plans are designed to cover your income in the event you become sick or injured and are unable to work. It covers a percentage of your income up to a maximum benefit amount and begins after a waiting period of 30 days. The disability plan offered by the City is a blended short-term/long-term plan.

You can find a copy of the CAPF Features and Benefits Summary below. The disability plan starts after the waiting period has been satisfied and pays a benefit of 80% of wages for non-industrial disability and 70% of wages for industrial disability up to $10,000 per month.

Monthly Cost	$29.50 per month–(Effective 10/1/2019)
Percentage of Wages Protected	80% of wages Non Industrial Disability 70% of wages Industrial Disability 100% of wages for Catastrophic Disabilities for up to 30 months – not to exceed maximum monthly benefits No reductions for Workers Compensation Permanent Disability Settlements
Maximum Benefit	$10,000 per month, tax free
Waiting Period	30 Calendar Days – Earlier reduced benefits may be payable based on lack of personal leave down to zero days. $750 per month minimum benefit after 60 days ($500 per month if industrial caused). Freeze of personal leave after 60 days. No benefits are payable if working full-time light or modified duty.
Benefit Period	Lifetime Coverage Sickness, Accident and Pregnancy
Freeze of Sick Leave Option	After 60 Calendar Days
Sick Leave Integration Benefit	After 60 days, you must use 50% sick leave and receive a 50% benefit from the Plan or use 100% sick leave and receive $750 per month ($500 per month if Industrial Caused)
Cost of Living Benefit (COLA)	4% compounded per year (years 2-7) thereafter, CPI increase to age 65 and then benefits continued lifetime.
Musculoskeletal & Connective Tissue Disorders	Fully Covered. Lifetime coverage – 2 years own occupation definition. Restrictions Apply.
Benefits Payable During Challenged Workers Compensation Cases	After 60 calendar days – 70% of wages to a maximum benefit of $10,000 per month (repayable only if settled in your favor)
Waiver of Payment	Waiver of Payment after no-pay status
Minimum Monthly Benefit	$750 per month – paid in addition to personal leave after 60 calendar days ($500 per month if industrial caused)
Stress & Psychological	Four (4) months per occurrence. Twenty (20) months lifetime benefit (5 occurrences per lifetime). A participant must return to work for one (1) year between claims.
Pre-Existing Medical Condition Coverage	If you enroll during your initial enrollment period, all pre-existing medical conditions will be covered once you have been in the plan for twenty-four / forty eight months. Unless you are eligible for the Prior Coverage Credit – otherwise preexisting medical conditions will not be covered.
Survivorship Benefit	Nine months additional benefits to dependent beneficiary
Death Benefit	$15,000 death benefit on or off duty – natural accidental or terminal illness (payable and delivered usually within 24 hours of notification)
Ownership of Plan	Owned. Operated and managed by its participants through a representative Board of Directors (non-profit California Corporation since 1985).

California Association of Professional Firefights, a non-profit mutual benefit association.
(209) 223-3971 or (800) 832-7333
www.capf.org

Additional Benefits and Value Adds

PLANS TO HELP YOU SAVE

Program & Discount Resources

Value Added Resources through VOYA

Employee Assistance Program (EAP)

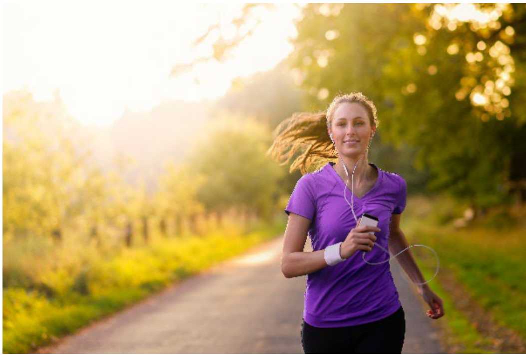
Healthcare FSA

Dependent Care FSA

PROGRAM & DISCOUNT RESOURCES

Delta Dental Amplifon Hearing Aid Discount

You now have access to discounts on hearing aids through Amplifon Hearing Health Care. Delta Dental selected Amplifon, a leader in hearing health care, to act as your personal concierge. They'll guide you through every step, from using your discounts to finding the right products and care to match your hearing needs. Call Amplifon at **(888) 779-1429** to be connected to a **Patient Care Advocate.**



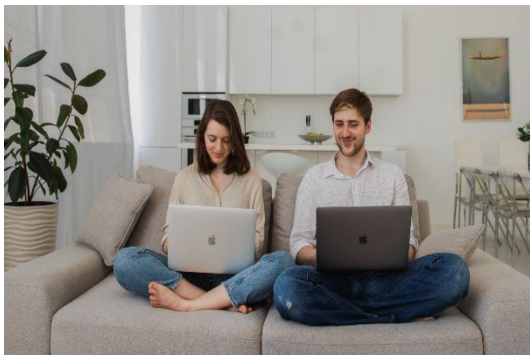
Delta Dental Qualsight Lasik

Because Delta Dental has selected QualSight to offer you access to discounts on LASIK services. Through QualSight, you can save 40-50% off the national average price of Traditional LASIK along with big savings on Custom and Custom Bladeless LASIK procedures! Call QualSight at **(855) 248-2021** for more information.

VSP TruHearing

VSP Vision Care members can save up to 60% on the latest brand name hearing aids. Dependents and even extended family members are eligible for exclusive savings, too! Call TruHearing at **(877) 396-7194** and mention **VSP**.

VALUE ADDED RESOURCES THROUGH VOYA



Contact Compsych Guidance Resources

Phone
(877) 533-2363

Website
www.guidanceresources.com
WEB ID: MY5848i

Call Guidance Resources for access to your Estate Planning, Financial Planning, Work-Life Solutions, Legal Guidance and more.

Estate Planning Benefits

Estate Guidance is an employee benefit that offers you the ease and simplicity of online will preparation. Access the site using the directions provided and supply the information when prompted. Your will can be completed online. In addition, you will receive instructions about how to execute your will and store it, as well as access to Web-based support. Please note that this is only for a simple will that does not cover credit shelter trust, printing or certain features.

Financial Benefits

In-house staff includes Certified Public Accounts (CPAs), Certified Financial Planners (CFPs) and other professionals are who exclusively dedicated to providing financial information by phone. On staff financial experts can help you with your personal financial challenges.

Work-Life Solutions

Call any time for assistance with topics including: finding child or elder care, housing searches, seeking financial assistance, finding pet care, sending a child off to school, and planning a major project or event.

Legal Guidance

Schedule a phone appointment for you with one of the staff attorneys. Attorneys can help with: family law matters, bankruptcy and credit issues, landlord/tenant issues, real estate and foreclosure questions, immigration concerns and wills and living wills.

Funeral Planning and Concierge Service

The death of a family member is one of life's most stressful times. It requires grieving survivors to quickly make many decisions about funeral services, something most of us know little about. This service will assist with funeral planning and negotiation at time of need as well as pre-planning tools that can be used to research and document decisions and wishes. Everest is an independent service that works exclusively on behalf of their clients and is not associated with any funeral home or service provider. If you would like additional information or assistance, contact an Everest Service Advisor at **(800) 913-8318.**

Travel Assistance

The Voya Travel Assistance program offers you enhanced security for your leisure and business trips. You and your eligible dependents will have toll-free or collect call access to the Voya Travel Assistance customer service center. You can also access the services provided on the Voya Travel Assistance website, 24 hours a day, 365 days a year – from anywhere in the world! Call **(800) 859-2821 or (202) 296-8355 for more info!**

Online portal: https://eservices.europassistance-usa.com/sites/Voya; Group ID: N1VOY, Activation code: 140623.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE EAP

Phone
(877) 533-2363

Website
www.Guidanceresources.com
WEB ID: MY5848i

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 ComPsych GuidanceResources 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
- 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

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**

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

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 Benefit Coordinators Corporation (BCC).

How the Healthcare FSA 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 $2,850, 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 01/01/2024 and 12/31/2024 and claims must be submitted for reimbursement no later than 03/31/2025. If you don't spend all the money in your account, you forfeit the leftover balance.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- You must re-enroll in this program each year.

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?

Customer Service

Phone: (800) 685-6100

Online Access: www.BenXcel.com

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 Benefit Coordinators Corporation.

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. Didn't know this…Extra info.

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.

IMPORTANT PLAN INFORMATION

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

- 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 City of Merced if your domestic partner is your tax dependent.

PLAN CONTACTS

Plan Type	Provider	Phone Number	Website
Medical	Anthem Blue Cross Anthem ID #: on ID Card Subscriber #: Employee SSN Group Numbers: • Core Plan: 175075M529 • Buy Up Plan: 175075M521	(800)967-3015 Claims Address: Anthem Blue Cross PO Box 60007 Los Angeles, CA 90060	Anthem.com
Medical	Carrum	(888)855-7806	My.carrumhealth.com
Prescriptions	Express Scripts (ESI) Pharmacy Services ESI ID #: on ID card • Core Plan: 175075M529 • Buy Up Plan: 175075M521	(800)711-0917	Express-scripts.com
Dental	Delta Dental No cards issues Subscriber #: Employee SSN Group Number: 565	(800)765-6003	Deltadentalins.com
Vision	VSP No cards issues Subscriber #: Employee SSN Group Number 12097042	(800)877-7195	Vsp.com
Life and AD&D	Voya Group #: 316407-162	(800)955-7736	www.voya.com
Disability	Voya Group #: 316407-162	(800)977-5176	www.voya.com
FSA	BCC Group #: City of Merced	(800)335-8227	www.benxcel.com
City of Merced Insurance Department	Maggie Lemos	(209)385-6979	lemosm@cityofmerced.org

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.

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.

Medicare Part D Notice

Important Notice from City of Merced About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City of Merced and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. City of Merced has determined that the prescription drug coverage offered by the City of Merced is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your City of Merced 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 City of Merced is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your City of Merced 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 City of Merced 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 Human Resources Department 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 City of Merced 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:	09/01/2023
Name of Entity/Sender:	City of Merced
Contact-Position/Office:	Human Resources Department
Address:	678 W. 18tjh Street, Merced, CA 95340
Phone Number:	(209) 388-7100

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 plan administrator at (209) 388-7100

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 (209) 388-7100.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in City of Merced'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 City of Merced'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 31days 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 City of Merced's 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 City of Merced's describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Human Resources at (209) 388-7100.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 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 January 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 9.12% in 2023 of your modified adjusted household income.

MERCED