2024 BENEFITS

City of Clovis Benefit Guide

CONTENTS

MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

GETTING STARTED

2024 BENEFITS
January 1, 2024
through
December 31, 2024

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

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid. These documents can be obtained by contacting Personnel and on the City's website: www.cityofclovis.com under the Benefits tab.

A list of plan contacts is included at the back on page 40.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

In general, employees who work 40 hours or more hours per week are eligible for the benefits outlined in this overview. Regardless of the plan chosen by the employee, the City contributes a fixed amount toward the premium which is based upon 90% of the premium of the lowest cost medical HMO plan.

Full-time employees may opt out of coverage with proof of other group coverage.

Active Employment

An employee will be deemed in "active employment" status:

- Each day you are actually performing services for the City
- Each day of a regular paid vacation or other paid time off
- A regular non-working day, provided you were actively at work on your last preceding scheduled regular working day and the following regularly scheduled day

Any day on which you were absent from work during an approved FMLA leave or solely due to your own health status.

WHO'S ELIGIBLE FOR BENEFITS? Continued

Eligible Dependents

When enrolling dependents, appropriate documentation and/or proof of dependent status is required by the City and will be requested by Personnel.

Accepted forms of proof include Marriage and Birth Certificates, Tax Returns, State Issued Declaration of Domestic Partnership, Adoption Certificate or Proof of Legal Guardianship.

An eligible dependent of an employee is:

- A legally married spouse
- A registered domestic partner
- A child, up to age 26 (for these purposes a "child" will include):
    - Biological Child
    - Stepchildren
    - Legally adopted children (including a child for whom legal adoption proceedings have been started), and
    - Any other child for whom you are required to provide health plan coverage under a Qualified Medical Child Support Order
    - A disabled child at any age, as long as he/she continues to meet the following conditions, as defined by Section 12102 of the Americans with Disabilities Act (ADA)

Non-Eligible Dependents

An eligible dependent does not include:

- A spouse following final decree of dissolution or divorce.
- Any person who is on active duty in a military service, to the extent permitted by law.

WHO CAN YOU COVER?

Retirees

Retirees under the age of 65 are eligible to purchase health benefits through the City. The Retiree Medical/Prescription plan is subject to Council approval. To be eligible for the Retiree Medical / Prescription Plan, a retired/retiring employee must be continuously covered in the Medical/ Prescription portion of the City's health plan through December 31 of the current plan year, as a full-time regular employee or a retired enrollee; or was continuously covered by a City approved group medical / prescription plan as a full-time regular City employee immediately preceding retirement for the City (see the Retiree Med-Prescription Plan Summary for more details).

Medicare While Working

If you are eligible to participate in the City's medical plans as an active employee and wish to continue working after reaching age 65, you have important options to consider when approaching Medicare eligibility. While you are still an active benefited employee under a City medical plan, you may be able to delay enrollment in some parts of Medicare without incurring a late enrollment penalty at a later date. Your City medical plan remains primary to Medicare while you are working.

For details of what's covered under Medicare, how to enroll, and your option regarding Medicare coverage, contact your local Social Security office or visit www.medicare.gov on the web.

Change In Dependent Eligibility

It is the employee's responsibility to notify the City's Personnel Division **within 30 days or sooner** of a dependent's change in status that would make the dependent eligible or ineligible for benefit coverage. Some examples of a change in dependent status are birth, death, adoption, divorce, or the obtaining of other coverage.

Continuation of Coverage (COBRA)

While you must delete your ineligible dependent within 30 days of the loss of eligibility, failure to delete your ineligible dependent within 60 days of loss of eligibility will result in a loss of continuation of coverage rights (COBRA) for your dependents.

CHANGING YOUR BENEFITS

Click to play video

Life Happens

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

New Full-time Hire

Medical, Dental, and Vision coverage are effective the date of hire when you complete and return the enrollment form within 30 days of the date of hire. Life insurance is effective the first of the month following the date of hire.

Open Enrollment

Once a year, usually during the months of October or November, the City holds an Open Enrollment period. During this time, eligible employees may change to a different medical plan, enroll in the dental plan, the vision plan, or choose the cash-in-lieu option (waiver). You may also add or delete dependents to your medical, dental, or vision plan.

Supporting documentation will be required by Personnel to add or delete new dependents.

Change in Beneficiaries

Certain events in your life such as marriage, divorce, or a death in the family can affect who you name as your designated beneficiary for certain benefits. You may change your beneficiary(ies) at any time. If you wish to do so, you can obtain most beneficiary forms from Personnel. You can designate a beneficiary for:

- Deferred Compensation
- Life Insurance
- Retirement - CalPERS

CHANGES IN COVERAGE

Special Enrollment Rights as Provided by HIPAA

- You initially declined coverage under the plan because you had coverage under another plan, and subsequently incurred a loss of coverage under the other plan.
- Occurrence of certain events such as birth, adoption, placement for adoption or marriage.
- Eligibility for state premium subsidies under the Children's Health Insurance Program or State Children's Health Insurance Program.
- Loss of coverage under Medicaid, The Children's Health Insurance Program or State Children's Health Insurance Program.

Qualifying Life Event

You may experience certain events during the plan year that would allow or require you to change your or your dependent's medical coverage. Change will usually be effective the first of the following month. If any of the following events occur, you must change your benefit coverage **within 30 days of the event**:

- Change in your legal marital or domestic partner status, including marriage, death of your spouse / domestic partner, divorce, legal separation or annulment.
- Change in the number of your dependents, including birth, adoption, placement for adoption or death of your dependent.
- Change in your employment status, including termination or commencement of employment of you, your spouse, your domestic partner or your dependent.
- Change in work schedule for you or your spouse / domestic partner, including an increase or decrease in the number of hours of employment, a switch between full-time and part-time status, a strike, lockout or commencement or return from an unpaid leave of absence.
- Your dependent satisfies or no longer meets the eligibility requirements for dependents.
- A change in the place of residence or worksite of you or your spouse / domestic partner (This move must affect your coverage options).
- You, your spouse / domestic partner or your dependents lose COBRA coverage.
- You, your spouse/domestic partner or your dependents enroll for Medicare or Medicaid or lose coverage under Medicare or Medicaid.
- If the plan receives a decree, judgment or court order, including a QMSCSO pertaining to your dependent, you may add the child to the plan or drop the child from the plan.
- A significant change in benefit or cost of coverage for you or your spouse/domestic partner.
- Your spouse/domestic partner employer provides the opportunity to enroll or change benefits during an open enrollment period.

ENROLLING FOR BENEFITS

Benefit Resources

You can access more information by visiting:

- The Chalkboard
- http://www.ci.clovis.ca.us/Departments-Services/Personnel/Employee-Resources
- Contact the Personnel office at (559) 324-2725

Enrollment Instructions

When you are hired, you receive this Employee Benefits Handbook, as well as brochures describing your different benefits. You have 30 calendar days to make your choices and most of your benefits will be effective the date of hire. Read over all of the material carefully. If you have any questions and require assistance in making these important choices, you can contact Personnel at (559) 324-2725.

Here are some basic guidelines you need to keep in mind when going over these choices:

1. Review the section of this Handbook on medical plans, the health plan comparison, as well as the enrollment packets to determine which medical plan suits your health and financial needs.
2. Determine your life insurance needs and decide if you wish to buy additional coverage above what is provided by the City.
3. Study the Deferred Compensation information.
4. If you have medical coverage through another source, such as a spouse, you may want to consider the benefit waiver option. Proof of other group coverage for you and your dependents will be required in order to qualify for this option.

Once you have made your choices, you should complete the appropriate enrollment forms and turn them into Personnel with the required documentation within 30 calendar days of your hire date. Be sure to include all your eligible dependents and complete all beneficiary forms.

HEALTHCARE

MAKE TIME FOR HEALTH

OUR COMMITMENT

We believe that our employees should have access to healthcare coverage that promotes preventive care and helps cover the cost of illness.

Eligible employees and their eligible dependents can enroll in medical, dental, and vision coverage through the City of Clovis benefits program.

Medical

We offer 5 medical plans. Preventive care is fully covered under all plans if obtained in-network. Your costs for other services will depend on which plan you choose. Review the network provider information and out-of-pocket costs such as deductible, coinsurance, and prescription drugs so you can choose the best fit for your health concerns and budget.

Dental

Some people don't like going to the dentist, but no one likes big dental bills. Regular checkups and cleanings are fully covered and can identify issues before they become serious. And if you do need dental services, insurance helps cover the cost for fillings, gum disease, and more.

Vision

An eye exam can uncover health conditions you may not know you have, such as glaucoma, or even high blood pressure. Our vision plan helps cover the cost of eye exams, eyeglasses, and contact lenses to ensure you're seeing and feeling your best.

WHICH PLAN IS RIGHT FOR YOU?

Consider an HMO (Health Maintenance Organization) if:

- You want lower, predictable out-of-pocket costs
- You like having one doctor to manage your care
- You are happy with the selection of network providers
- You don't see any doctors that are out-of-network
- You have convenient access to Kaiser facilities

Plans To Consider

- Kaiser HMO
- Anthem Premier HMO

Consider a PPO (Preferred Provider Organization) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers

Plans To Consider

- Anthem Classic PPO

Consider a HDHP (High Deductible Health Plan) if:

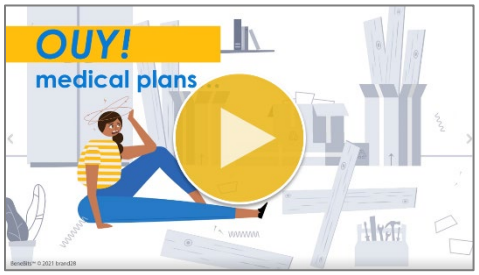
- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers
- You want tax-free savings on your healthcare costs
- You want to build a Health Savings Account (HSA) for future healthcare costs for you and your eligible family members
- You want an extra way to add to your retirement savings

Plans To Consider

- Kaiser HDHP
- Anthem HDHP

All About Medical Plans

Medical plans can seem hard to understand, but once you understand the building blocks you will be able to choose the best plan for you and your dependents.



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YOUR RESPONSIBILITY

There are certain regulations that apply to the health, dental and vision plans. You have the option of enrolling in the medical, dental and vision plan or waiving the medical plan (with proof of other coverage) and enrolling in the dental and vision.

- Enrollment: a universal enrollment form *and* a dental/vision form must be completed to enroll in coverage. A verbal request for coverage is not sufficient, even if you were previously enrolled. If your coverage has been canceled due to a leave of absence (without pay), you must complete an enrollment form and return it to Personnel within 30 calendar days of eligibility. If you are covered under another plan such as a spouse's plan, and lose that coverage, you have 30 calendar days to enroll in a City health plan. Otherwise, you will have to wait until the Open Enrollment period.
- Dependents: you may only add new dependents to your medical, dental, and vision plans by completing the appropriate change form and returning it to Personnel within 30 calendar days of birth, adoption, marriage, or proof of domestic partner registration. Otherwise, you will have to wait until Open Enrollment.
- Termination of Coverage: dependents who are no longer eligible must be dropped from the City's group plan(s). It is your responsibility to notify the City within 30 calendar days when a dependent child, spouse, or domestic partner is no longer eligible. A universal enrollment form removing the ineligible dependent must be completed and returned to Personnel. Dependents who are no longer eligible for coverage may continue coverage under COBRA law.
- Waiver Option: if you are a full-time employee and have other health or dental / vision coverage under another group plan, for example through your spouse, you have the option of waiving coverage and receiving a cash payment. For the exact amount of cash, see your bargaining unit's Benefit Summary. The cash payment is taxable and will be included in your paycheck. You may only apply for the waiver option within 30 calendar days of your hire date, during the Open Enrollment period, or within 30 days of a qualifying event. To be eligible for the waiver, you must complete the Health Waiver Form and return it to Personnel, along with proof of other coverage for yourself and all dependents.
- Late Entrants: employees who decline medical coverage for themselves and/or their dependents during the initial enrollment period and then, more than 31 days later, request coverage, will be considered to be Late Entrants. Late Entrants may be subject to an exclusion from coverage until next open enrollment. However, an eligible employee will not be considered a Late Entrant for employee and/or dependent coverage if late enrollment is made under one of the circumstances described below and any required information or proof is furnished.
- Expectations:

    1. Termination of Other Health Coverage – Request for enrollment is made within 30 days after termination of other health coverage, and (a) the employee certifies that enrollment under this plan was initially declined solely due to the other coverage; and (b) termination of the other group coverage due to termination of employment or eligibility, the involuntary termination of the previous coverage, cessation of the employer's contribution towards the individual's coverage, death of spouse or divorce; (c) significant change in cost or scope of coverage in the spouse's employer plan.
    2. Court order: Request for enrollment is made within 30 days after issuance of court order that coverage be provided for the spouse and/or minor child(ren) of a covered employee.

Medical (HMO)

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.

	Kaiser Traditional HMO	Anthem Premier HMO	Kaiser Deductible HMO (Extra Help)
	In-Network	In-Network	In-Network
Calendar Year Deductible[1] Individual Family	 $0 $0	 $0 $0	 $4,500 $9,000
Calendar Year Out-of-Pocket Maximum[4] Individual Family	 $1,500 $3,000	 $1,000 $2,000	 $6,000 $12,000
Office Visit Primary Care Specialist	 $15 copay $15 copay	 $15 copay $15 copay	 40% after deductible 40% after deductible
Preventive Services	Plan pays 100%		
Chiropractic	$15 copay (30 visits per year)	$10 copay (40 visits per year)	Not covered
Lab and X-ray Complex imaging (MRI, CT)	$10 copay $50 copay	Plan pays 100%	40% after deductible
Urgent Care	$15 copay	$15 copay	40% after deductible
Emergency Room	$100 copay (copay waived if admitted)	$100 copay (copay waived if admitted)	40% after deductible
Inpatient Hospitalization	Plan pays 100%	Plan pays 100%	40% after deductible
Outpatient Surgery	$15 copay	Plan pays 100%	40% after deductible
PRESCRIPTION DRUGS			
Calendar Year Deductible	N/A	N/A	$250 per individual
Out-of-Pocket Maximum	Combined with medical	Combined with medical	N/A
Retail Generic Preferred Brand Non-Preferred Brand Specialty Supply Limit	 $10 copay $30 copay $30 copay - 30 Days	 $10 copay $20 copay $35 copay 30% (up to $100) 30 Days	 30% after deductible (up to $50) 40% after deductible (up to $100) 40% after deductible (up to $100) - 100 Days
Mail Order Generic Preferred Brand Non-Preferred Brand Specialty Supply Limit	 $20 copay $60 copay $60 copay - 100 Days	 $20 copay $40 copay $60 copay 30% (up to $100) 90 days	 30% after deductible (up to $50) 40% after deductible (up to $100) 40% after deductible (up to $100) - 100 Days

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1st through December 31st.
[4]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

Medical (PPO)

	Anthem Classic PPO
	In-Network
Calendar Year Deductible[1] Individual Family	 $500 $1,000
Calendar Year Out-of-Pocket Maximum[4] Individual Family	 $3,000 $6,000
Office Visit Primary Care Specialist	 $35 copay $35 copay
Preventive Services	Plan pays 100%
Chiropractic	$25 copay (12 visits per year)
Lab and X-ray	Plan pays 100% after deductible
Urgent Care	$35 copay
Emergency Room	$100 copay, and 20% after deductible (copay waived if admitted)
Inpatient Hospitalization	$250 copay, and 20% after deductible (copay waived for emergency admissions)
Outpatient Surgery	20% after deductible
PRESCRIPTION DRUGS	
Calendar Year Deductible	N/A
Out-of-Pocket Maximum Individual Family	 $2,000 $4,000
Retail- 30 Day Supply Generic Preferred Brand Non-Preferred Brand	 $10 copay $20 copay $35 copay
Mail Order- 90 Day Supply Generic Preferred Brand Non-Preferred Brand	 $20 copay $40 copay $60 copay

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1st through December 31st.
[4]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

VOLUNTARY Smart90 PROGRAM (ANTHEM PPO PLAN)

Saving On Your Medications

Don't throw money away. You can save yourself and our medical plan a lot of money if you are smart in buying your prescriptions.

- Shop around for the best prices, even if your copay is the same.
- If your doctor prescribes a brand name drug, ask if there is a generic equivalent that will work for you. Generics are less expensive.
- If you are on maintenance medications with ongoing prescriptions, it is cheaper to order a 90 day supply through mail order rather than a 30 day supply at your local pharmacy. If you purchase at your local pharmacy, you pay for 3 months. On our plans, with mail order you pay for 2 months and get three months of medication, a 33% savings to you.
- Now through the Voluntary Smart90 plan you can get the same savings and convenience at designated local pharmacies – CVS or Walgreens. See the frequently asked questions below.

Member FAQ

Q: How can I get my long-term medication?
A: As part of your prescription benefit managed by Express Scripts, you have two ways to get up to a 90-day supply of your long-term maintenance medication (those drugs you take regularly for ongoing conditions such as high blood pressure, diabetes, or high cholesterol). You can conveniently fill those prescriptions either through home delivery from the Express Scripts Pharmacy or at a retail pharmacy in your network.

Q: How many retail pharmacies are available to me?
A: There are thousands of retail pharmacies in the network. To locate one, login to express-scripts.com and click "Find a Pharmacy" from the menu under "Prescriptions," network pharmacies will be noted in your search results. Or, call Express Scripts at the number listed on the back of your member ID card. You can also use the Express Scripts mobile app on your digital device to locate a participating pharmacy.

Q: What is the advantage of a 90 day supply vs. a 30 day supply?
A: By getting up to a 90 day supply, you'll make fewer trips to the pharmacy and you'll only need to make one payment every three months. Also, there's usually a savings for getting one 90-day supply vs. three 30-day supplies at retail. Plus, you'll be less likely to miss a dose since you won't have to refill as often.

Q: How do I get started?
A: The network of pharmacies that can fill 90-day supplies for long-term medications will be part of your prescription benefit beginning January 1, 2024. You can review your 90-day options by logging in to express-scripts.com. If you are a first-time visitor to express-scripts.com, take a minute to register (be sure you have your member ID number handy). You can also use the Express Scripts mobile app on your digital device to locate a participating pharmacy or call Express Scripts at the number listed on the back of your member ID card.

Q: Do I need to get a new prescription from my doctor for 90 day supply?
A: When you choose to get a 90-day supply of your maintenance medication through home delivery from the Express Scripts Pharmacy, we can contact your doctor to get a new prescription. If you choose to get up to a 90-day supply at a participating retail pharmacy, you can ask the pharmacist to contact your doctor to get a new 90-day prescription for you, or to transfer your current 90-day prescriptions from another pharmacy.

Q: I already use home delivery from the Express Scripts Pharmacy to get my long-term drugs. Do I need to change anything?
A: No. If you're using home delivery from the Express Scripts Pharmacy for your long-term drugs, you don't need to do anything further. However, if you have additional questions, feel free to call Express Scripts at the number listed on the back of your member ID card.

Medical (HDHP)

	Kaiser Traditional HDHP	Anthem Premier HDHP
	In-Network	In-Network
Calendar Year Deductible[1] Individual Family	 $3,200 $6,400	 $3,200 $6,400
Calendar Year Out-of-Pocket Maximum[4] Individual Family	 $3,200 $6,400	 $3,200 $6,400
Office Visit Primary Care Specialist	 Plan pays 100% after deductible Plan pays 100% after deductible	 Plan pays 100% after deductible Plan pays 100% after deductible
Preventive Services	Plan pays 100%	
Chiropractic	Plan pays 100% after deductible (24 visits per year)	$15 copay (30 visits per year)
Lab and X-ray	Plan pays 100% after deductible	Plan pays 100% after deductible
Urgent Care	Plan pays 100% after deductible	Plan pays 100% after deductible
Emergency Room	Plan pays 100% after deductible	Plan pays 100% after deductible
Inpatient Hospitalization	Plan pays 100% after deductible	Plan pays 100% after deductible
Outpatient Surgery	Plan pays 100% after deductible	Plan pays 100% after deductible
PRESCRIPTION DRUGS		
Calendar Year Deductible	Combined with medical	Combined with medical
Out-of-Pocket Maximum	Combined with medical	Combined with medical
Retail Generic Preferred Brand Non-Preferred Brand Supply Limit	 $0 $0 $0 30 Days	 $0 $0 $0 30 Days
Mail Order Generic Preferred Brand Non-Preferred Brand Supply Limit	 $0 $0 $0 90 Days	 $0 $0 $0 100 Days

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1st through December 31st.
[4]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

DENTAL

OUR PLANS

Ameritas DPPO

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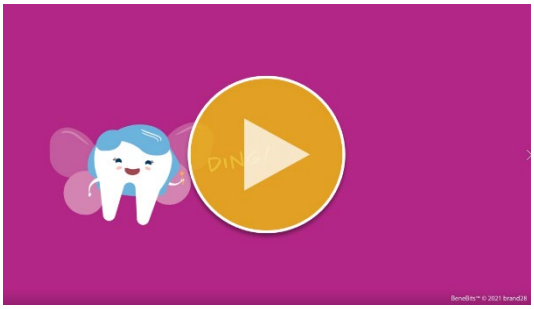

Why Sign Up For Dental Coverage?

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

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

Dental insurance covers three types of treatments:

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

Dental Plan

Regular visits to your dentists can protect more than your smile; they can help protect your health. To see if your dentist is a participating provider in the network, please contact Ameritas at www.ameritas.com or call (800) 487-5553.

	Ameritas	
	In-Network	**Out-of-Network***
Annual Deductible Individual/ Family	$0 / $0	$25 / $75
Calendar Year Maximum	$2,000 per member	$1,500 per member
Diagnostic & Preventive Oral Exam X-Rays Cleanings	100%	80%
Basic Services Restorative Amalgams/Composites Periodontics (Gum Disease) Endodontics (Root Canal) Simple Extractions	80%	80%
Crown / Bridges Crowns Bridges Dentures Implants Bone Augmentation	80%	60%

	Enhancements
Dental Rewards *You earn dental rewards by submitting at least one claim for dental expenses incurred during the benefit year, while staying at or under the threshold amount ($750) for benefits received for that year*	Allows qualifying plan members to carryover part of their unused annual maximum ($250 up to $1,000 maximum).
Fusion Dental	Members can use a portion of their dental Calendar Year Maximum ($150) towards out-of-pocket vision expenses anytime throughout the year.
LASIK Advantage *This program offers coverage for LASIK and related procedures*	Members can earn a lifetime benefit per eye, and the benefit amount increases over time, with the highest coverage provided at year 4. For example: Year 1 and 2 = $250 Year 3 and 4 = $500.
SoundCare *Offers coverage for Hearing Exams, Hearing Aid and Hearing Aid Maintenance, with no deductible*	• Annual Hearing Exam = 100% covered, up to $75. • Hearing Aids = 50% covered with up to $400 in year 1, $600 in year 2, $800 in year 3 (per ear). • Hearing Aid Maintenance = 100% covered, up to $40.

*Out of Network dentists are based on Usual, Customary & Reasonable Fees (UCR); Amounts over the UCR are the member's responsibility
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.

VISION

OUR PLANS

VSP

Click to play video

Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. Even if you don't need vision correction, it is important to check the health of your eyes with annual eye exams, which can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

Vision Plan

Routine vision exams can not only correct vision, but also detect more serious health conditions. We offer you a vision plan through VSP, Vision Service Plan. The VSP plan allows you to go to any provider; however your benefits will be greater if you use one of the VSP contracted providers, including Costco. VSP now covers standard progressive lenses in full.

	VSP	
	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	Combined with exam Combined with exam Combined with exam 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	$100 allowance Once every 12 months	Plan pays up to $70 Once every 12 months
Contacts **(In lieu of glasses)** Benefit Frequency	$150 allowance Once every 12 months	Plan pays up to $105 Once every 12 months
TruHearing Hearing Aid Discount	Call TruHearing at (877) 396-7194 and mention VSP	Not Covered

ENGAGE

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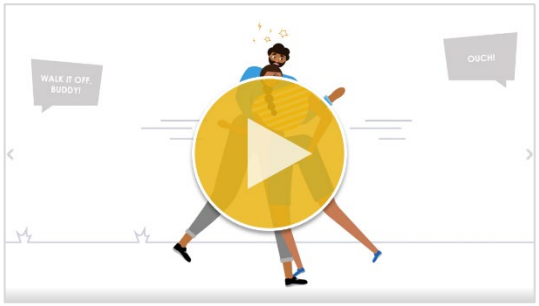
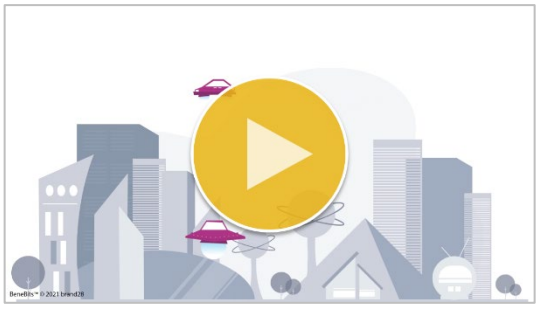


Urgent Care vs ER



Virtual Healthcare

Maximize Your Healthcare

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits

Health Enhancing Programs

In addition to medical coverage, we provide these programs and services to help you access care when and how you need it and address special health concerns:

- **Carrum Health** – A surgery benefit
- **Livongo** – Living with diabetes
- **Hinge** – Conquer back and joint pain without surgery

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	$0
Online visit 	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	$
Office visit 	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	$$
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	$$$
Emergency room 	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	$$$$$

ALTERNATIVE FACILITIES

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

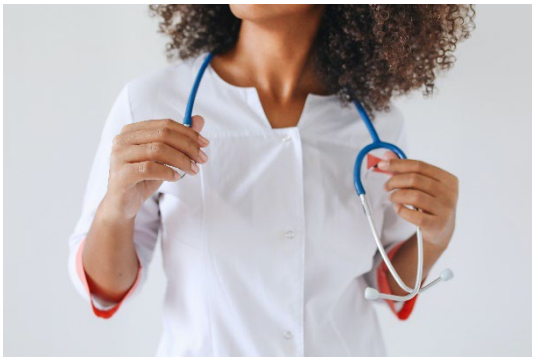
Need	Alternative	Features	Savings
Surgery 	Ambulatory Surgery Center (ASC)	▪ Specializes in same-day surgeries ▪ Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more ▪ Held to same safety standards as hospitals	Up to 50% over hospital stay*
Physical therapy 	Free-standing physical therapy center	▪ Important part of the recovery process after an injury or surgery	40 to 60% over a hospital setting*
Sleep study 	Home testing	▪ Diagnoses sleep apnea and other conditions ▪ Cost is often covered by insurance if considered medically necessary	Approx. $4,500*
Infusion therapy 	Home or outpatient infusion therapy	▪ For drugs that must be delivered by intravenous injections, or epidurals ▪ Delivered by licensed infusion therapy provider ▪ Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% over hospital stay* **in-network*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on your plan's website; or call member services for assistance.

Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings. Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

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.

LIVING WITH DIABETES?

THE BEST PART?

The program is offered at **no cost** to employees with diabetes and coverage through a City of Clovis Anthem HMO (effective 01/01/24), Anthem PPO, or Anthem High Deductible Health Plan (HDHP) Health Plan.

Teladoc HEALTH

Take A Look At **Livongo For Diabetes** From Teladoc Health

Livongo for Diabetes makes diabetes management simple. This is a personalized experience that helps members understand their blood sugar, develop health lifestyle habits, and improve glycemic control.

Why Livongo for Diabetes?

We use data and technology to monitor your personal health status and give you support when you need it. Coaching and recommendations tailored to your specific needs will help you manage your diabetes in the long term.

What You Get With Livongo For Diabetes

- **Effortless data collection**: Members will receive a free cellular meter that provides real-time feedback for glucose readings, unlimited strips and lancets, removing barriers for checking, as well as food and activity tracking to understand lifestyle habits.
- **Personalized health signals**: Members will have access to health challenges that drive small daily changes that result in big wins. The Health Nudges deliver calls to action when members are most receptive.
- **Human-centered approach:** Members have 24/7 remote monitoring with emergency outreach in the event of and out of range reading as well as access to 1:1 live coaching from Livongo expert coaches.

How Do I Sign Up?

To sign up or to learn more, visit join.livongo.com/PRISM-EXPRESSSCRIPTS/register or call Livongo Member Support at (800) 945-4355 and have registration code “PRISM-EXPRESSSCRIPTS” ready. Once you have completed your registration, you will be prompted to download the mobile app as part of the enrollment process.

CONQUER BACK AND JOINT PAIN

Hinge Health

Hinge Health has coach-led Digital Care Pathways for chronic back and joint pain, as a replacement to surgery. With exercise therapy, behavioral health coaching, and a personalized education curriculum, Hinge Health has proven outcomes of participant pain reduction, depression and anxiety reduction, and 2 out of 3 surgeries avoided. Watch a video on HingeHealth at hingehealth.com/learn-more or register at www.hingehealth.com/PRISM

What Does The Program Include?

1. Personalized exercise therapy to improve strength and mobility in short, 15-minute sessions.
2. Personal care team to provide care, motivation, and support virtually.
3. Interactive education to teach you how to manage your specific condition, treatment options, and more.

How Much Does The Program Cost?

It's free for eligible participants. This includes the Hinge Health kit, which you can keep forever.

Who is Eligible?

Members, pre-65 retirees, and dependents 18+ enrolled in a PRISM medical plan through Anthem are eligible (includes PPO and HDHPs – HMOs will have access to Hinge beginning January 1, 2024).

CARRUM HEALTH SURGERY BENEFIT

Click to play video

WHERE CAN I GET MORE INFO?

Phone: (888) 855-7806

Web: www.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 the City of Clovis is sponsoring Carrum Health as a benefit to Anthem PPO or High Deductible Health Plan (HDHP) 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.

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.

BASIC LIFE AND AD&D INSURANCE

Basic Life and AD&D

The City provides a Basic life/AD&D insurance benefit through Lincoln, at no cost to the employee for those classified as full-time salaried employees. The plan will pay the following amount to your beneficiary at the time of death:

- All Non-Management and Memorial District – $50,000
- Spouse and Dependent Child Benefit - $10,000

If you are a management member, Memorial District, or Council member see Personnel for the benefit amount.

If you die while actively employed with the City, your beneficiaries will receive a cash benefit. There is also a living benefit option that provides payment of a partial benefit for terminally ill insured employees.

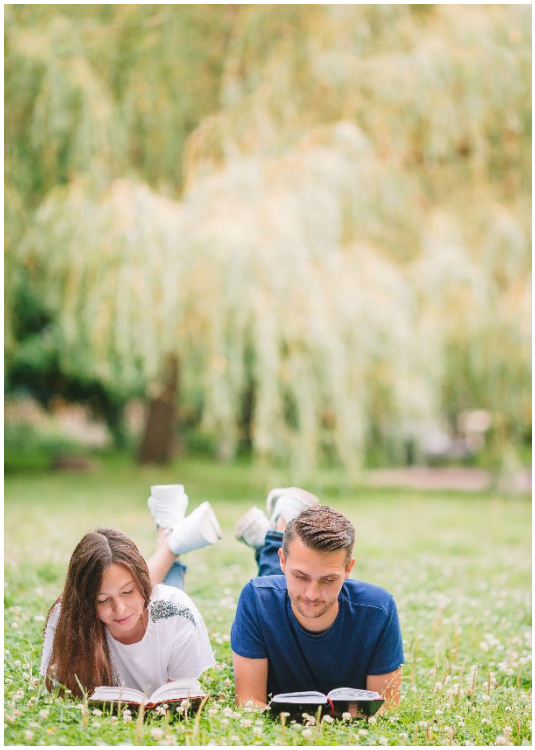
Don’t Forget to Name a Beneficiary

A beneficiary is the person or persons who will be paid if you die while covered by the plan. A person becomes your beneficiary only if you have named them on the card, you signed when you enrolled. If you are married and not naming your spouse as the beneficiary, the spouse must sign an acknowledgement. You may change your beneficiary at any time by completing a new form and returning it to Personnel.

Conversion (Termination of Employment)

You may convert your Basic Life insurance to individual coverage when you leave City employment. You must apply within 30 days of your termination date. If you are interested in conversion, contact the Personnel office.

VOLUNTARY LIFE INSURANCE



GUARANTEED ISSUE

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

Protecting Those You Leave Behind

Additional employee paid life insurance is also available through Lincoln. You may apply for additional coverage in multiples of $5,000 from $10,000 to $500,000. You may apply for coverage up to $100,000 without evidence of insurability within 30 day of your hire date. After the initial eligibility period, all amounts are subject to approval based on medical evidence.

As long as you are covered for the Basic Life/AD&D coverage, you may apply for coverage for your spouse and dependent children in the following amounts:

- Spouse. Increments of $5,000 with coverage between $5,000 to $250,000
- Children (through 26 years). $2,000 of coverage

The amount for either spouse or children cannot exceed 50% of the amount of your additional life insurance.

Coverage cost varies with age. Your monthly premium will not change until the plan anniversary date following the year in which you move to a new age bracket.

Don’t Forget to Name a Beneficiary

A beneficiary is the person or persons who will be paid if you die while covered by the plan. A person becomes your beneficiary only if you have named them on the form you signed when you enrolled. If you are married and not naming your spouse as the beneficiary, the spouse must sign an acknowledgement. You may change your beneficiary at any time by completing a new form and returning it to Personnel.

Conversion (Termination of Employment)

You may convert your Supplemental Life insurance to individual coverage when you leave City employment. You must apply within 30 days of your termination date. If you are interested in conversion, contact the Personnel office.

DISABILITY INSURANCE

State Disability Insurance (SDI)

SDI is available for all non-management and non-safety employees. SDI is employee paid by payroll deduction. If you are unable to work due to a non-work-related accident or illness, you are eligible to receive disability income for up to one year.

Full-time employees who pay into SDI may opt to integrate wages with SDI or PFL during a leave of absence. Integration of SDI or PFL benefits is a process in which an SDI or PFL weekly benefit amount is paid to the employee and the employee is also paid wages using their available accrued leave (sick, comp time, personal) to cover the difference between gross weekly wages and what is received from SDI/PFL. City of Clovis employees who are absent from duty due to a qualifying State Disability Insurance (SDI) or Paid Family Leave (PFL) reason, elect to integrate wages, and have been authorized to use the City paid leave benefit, shall be eligible to integrate wages and could receive up to 100% of their gross weekly wages. If you are going out on SDI or PFL please contact Personnel for an Integration Election Form.

Safety employees should contact their unions for disability insurance information.

Management employees' disability coverage is through Lincoln. Management can contact Personnel for information.

VOLUNTARY LONG-TERM CARE PLAN THROUGH TRUSTMARK

Why Universal LifeEvents?

- Universal Life/LifeEvents is a flexible permanent life insurance designed to last a lifetime
- The younger you are when you enroll, the more benefit you receive for same premium
- No medical exams or blood work required
- Keep your coverage at the same price and benefits if you change jobs or retire
- Apply for coverage for family members

Financial Security Even After A Loss

Protecting your loved ones is one of life's greatest responsibilities. When a family loses someone, in addition to grief, survivors may suddenly be faced with costly expenses and debts, and even a loss of income. Universal Life/LifeEvents can help.

Universal Life provides a consistent lifelong benefit, while, for the same rate, the Universal LifeEvents option offers a higher death benefit during your working years, when your needs and responsibilities are the greatest.

You can choose a plan and benefit amount that provides the right protection for you. Universal Life/LifeEvents insurance can mean those left behind are still able to pursue their own dreams and help ensure that the ending of one story won't stop the beginning of another.

Solving The Long-Term Care Issue

At any point in your life, you may need long-term care services, which could cost hundreds of dollars per day. Universal Life/LifeEvents includes a long-term care (LTC) benefit that can help pay for these services at any age. With either option, this benefit remains at the same level throughout your life, so the full amount is always available when you most need it.

How the Universal LifeEvents Option Works

- Higher death benefit during working years.
- Long-term care (LTC) benefits that stay the same throughout your life.
- Example: $25,000 Policy

Before Age 70	
Death Benefit	$25,000
LTC Benefit	$25,000
After Age 70	
Death Benefit	$8,333
LTC Benefit	$25,000

Death benefit reduces to one-third at age 70 or the beginning of the 15th policy year, whichever occurs last. Issue age is 18-64.

The LTC Benefit is an acceleration of the death benefit and is not Long-Term Care Insurance (except in LA and VA, where the LTC benefit is Long-Term Care Insurance). It begins to pay after 90 days of confinement or services, and to qualify you must meet conditions of eligibility for benefits. The LTC benefits provided by this policy may not cover all of the policyholder's LTC expenses. Pre-existing condition limitation may apply. Your policy will contain complete details. You should consult a financial advisor to determine if the long-term care benefits and the retirement benefits provided by this policy are right for you.

DEFERRED COMPENSATION

A governmental 457(b) deferred compensation plan is a retirement savings plan that allows eligible employees to supplement any existing retirement and pension benefits by saving and investing before-tax dollars through a voluntary salary contribution. Contributions and any earnings on contributions are tax-deferred until money is withdrawn. Distributions are usually taken during retirement, when many participants are typically receiving less income and may be in a lower income tax bracket than while working. Distributions are subject to ordinary income tax. The City offers the following option through MissionSquare:

- 457 (b) Deferred Compensation Plan. A retirement savings plan that allows participants to lower their current taxable income by making pre-tax contributions up to the annual limit specified by the IRS.

Eligibility

All permanent full time City employees are eligible for the 457(b) deferred compensation plan.

Contributions

In 2024, the maximum contribution is 100% of your includable compensation up to the limit specified by the IRS. You may choose between two different options to catch up and contribute more during the final years of your career:

- The Standard Catch-Up. Allows participants in the three years prior to normal retirement age to contribute up to double the annual contribution limit. The additional amount you may be able to contribute under the Standard Catch-Up option will depend upon the amounts that you were eligible to contribute to previous years but did not.
- Age 50 Catch-Up. Employees turning age 50 or older in 2024 may contribute an additional amount above the normal limit as specified annually by the IRS:
    - Normal Limit: $22,500
    - Age 50 Catch-Up: $7,500
    - 3-year pre-retirement catch-up: $45,000

DEFERRED COMPENSATION, continued

Rollovers

If you leave City employment, you may roll over your account balance to another 401(a), 401(k), 403(b) or another eligible governmental 457(b) plan if your new employer's plan accepts such rollovers. You may also roll over your account balance to an IRA.

Distributions

Qualifying distributions include:

- Retirement
- Permanent Disability
- Unforeseeable emergency as defined by the IRS
- Severance of employment as defined by the IRS
- Attainment of age 70 ½
- Death (upon which your beneficiary receives your benefits)
- Transfer to purchase service credits.

Taxes

Contributions are taken out of your paycheck on a pre-tax basis. Distributions are taxable as ordinary income during the years in which they are distributed or made available to you or your beneficiary(ies).

Roth IRA

A Roth IRA is also available to all full-time employees through MissionSquare. The tax advantages of a Roth IRA are future tax-free withdrawals after age 59 ½. Contributions may be made through payroll deduction. The contribution limit for most employees is $6,500 for 2024 (see your tax advisor).

FINANCIAL WELLNESS

PLANS TO HELP YOU SAVE

Health Savings Account (HSA)
Noble Credit Union

HEALTH SAVINGS ACCOUNT (HSA)

Click to play video

ARE YOU ELIGIBLE?

The HSA is not for everyone. You're eligible only if you are:

1. Enrolled in a HDHP.
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.
4. Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

A Personal Savings Account For Healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future.

How the Optum Bank HSA Works

- Complete an HSA enrollment form to set up an HSA account when you enroll in Anthem or Kaiser's High Deductible Health Plan (HDHP).
- You can contribute up to the 2024 annual limit set by the IRS:
  Individual: $4,150 per year
  Family: $8,300 per year
  Are you age 55 **or over?** You can contribute an additional $1,000 per year
- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but no penalties.

Find out more

- Eligible Expenses
- Ineligible Expenses.

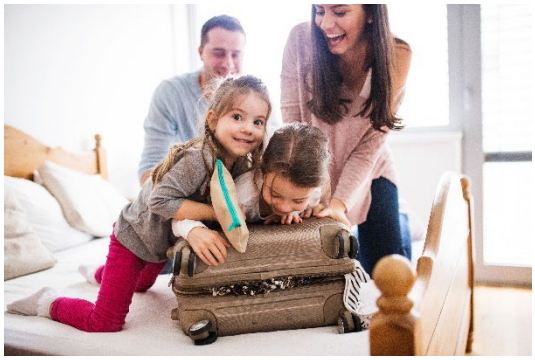
CREDIT UNION

Noble Credit Union

As a City employee you are eligible to join the member owned Noble Federal Credit Union. The Credit Union is member owned and offers lower rates on loans, higher savings rates and lower financial planning cost.

Benefits include:

- Financial Planning
- Shared Certificates of Deposit
- Money Market Advantage
- Retirement Accounts
- Loans



WELLBEING & BALANCE

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

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

A Happier, Healthier You

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

We offer programs to help you manage stress, chemical dependency, mental health, and family issues. Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE EAP

Phone
(559) 226-7437
Website
www.insighteap.com

Help For You And Your Household Members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Insight 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
- Up to 3 counseling sessions, every 6 months, per person; sworn safety employees are eligible for up to 6 counseling sessions, every 6 months, per person
- Unlimited web access to helpful articles, resources, and tools

Managing Life's Demands Can Be Difficult

Insight EAP can help you with a broad range of issues including:

- Emotional Distress
- Work-related Issues
- Divorce/ separation
- Relationships
- Marital, Family, and Parenting
- Life Transitions
- Drug/Alcohol Problems
- Aging Family Members
- Anxiety

IMPORTANT PLAN INFORMATION

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

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

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 the City of Clovis if your domestic partner is your tax dependent.

RETIREMENT

Medicare Eligible Retirees

Employees who are approaching Medicare age or have spouses approaching Medicare age or who may become Medicare eligible for other reasons such as disability need to go online and/or contact the Medicare Office as soon as possible in order to determine the rules for their eligibility. In some cases, there is a fairly short window of time to sign up for benefits to be eligible or to avoid significant ongoing penalties. Do your research and planning early to preserve all of your options and get the most for your healthcare dollar.

Retirees over the age of 65 are encouraged to contact an independent Medicare broker or a Medicare exchange, such as One Exchange at www.medicare.oneexchange.com or (866) 322.2824.

CalPERS

- Employees Hired On or After January 1, 2013. All employees hired after January 1, 2013 are subject to AB340 and AB197, California Public Employee Pension Reform Act of 2013. For Miscellaneous employees in this category, their retirement formula is 2% at age 62. For Safety employees in this category, their retirement formula is 2.7% at age 57.
- Employees Hired Before January 1, 2013. Your CalPERS retirement benefit is based on a formula that takes into account your age, years of service, and highest year's salary. For Miscellaneous employees, the retirement formula is 2.7% at age 55. For Safety employees, the retirement formula is 3% at age 50. Should you become disabled prior to retirement age, you may be eligible for a disability retirement benefit.

To apply for CalPERS retirement, obtain a CalPERS Retirement Application Booklet online at www.mycalpers.ca.gov or from the Personnel office. The "Employer Certification" is completed by Personnel. The completed form should be mailed directly to CalPERS.

Employees approaching retirement are encouraged to attend a CalPERS Retirement Planning Workshop. You can call CalPERS at 888.225.7377 for details.

CalPERS Optional Provisions

The City of Clovis elected and elects to be subject to the following optional provisions:

a) Section 21574 (Fourth Level of 1959 Survivor Benefits)
b) Section 20903 (Two Years Additional Service Credit under very limited circumstances for some individuals).
c) Section 20965 (Credit for Unused Sick Leave).
d) Section 20042 (One-Year Final Compensation). For members subject to PEPRA, use the three-year final compensation.
e) Section 20503 (To Remove the Exclusion of Persons Compensated on an Hourly Basis Hired on or After April 1, 1967, Prospectively from September 7, 2006.
f) Section 20325 (Optional Membership for Part-Time Employees) for local miscellaneous members only.
g) Section 21547.7 (Alternate Death Benefit for Local Fire Members Credited with 20 or More Years of Service).
h) Section 21548 (Pre-Retirement Option 2W Death Benefit).
i) Section 21024 (Military Service Credit as Public Service).
j) Section 20516 (Employees Sharing Cost of Additional Benefits).

PLAN CONTACTS

Plan Type	Provider	Phone Number	Address	Website
City of Clovis	Personnel Office	559-324-2725 559-324-2865 (Fax)	1033 Fifth Street Clovis, CA. 93612	www.ci.clovis.ca.us
Medical				
	Kaiser Permanente HMO/HDHP	800-464-4000		www.kp.org
	Anthem HMO/PPO	800-967-3015		www.anthem.com/ca/prism
	Anthem HDHP	855-826-0710		www.anthem.com/ca/prism
	Optum HSA	866-234-8913		www.optumbank.com
Pharmacy				
	Express Scripts	877-554-3091		www.express-scripts.com
Dental				
	Ameritas	800-487-5553		www.ameritas.com
Vision				
	VSP	800-877-7195		www.vsp.com
Employee Assistance Program (EAP)				
	Insight	559-226-7437	6445 N Palm Ave., Suite #106 Fresno, CA. 93704	www.insighteap.com
Life Insurance				
	Lincoln Financial	877-275-5462		www.lfg.com
Deferred Compensation				
	MissionSquare	866-486-8813		www.missionsq.org
CalPERS		888-225-7377		www.calpers.ca.gov
Social Security		800-772-1213		www.socialsecurity.gov
Internal Revenue Services (IRS)		559-443-7741	2525 Capitol St. Fresno, CA. 93721	www.irs.gov
State of CA Employment Development Department (EDD)		800-480-3287		www.edd.ca.gov

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

HEALTH PLAN NOTICES

Notices must be provided to plan participants on an annual basis and are available this packet of open enrollment materials and include:

- **Marketplace Coverage Options**
- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

COBRA CONTINUATION COVERAGE

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

DEADLINE FOR FILING LAWSUIT UNDER ERISA AFTER EXHAUSTION OF ALL CLAIMS PROCEDURES

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan specific statute of limitations.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contract_____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

1. Employer name **City of Clovis**		2. Employer Identification Number (EIN) **94-6000311**
3. Employer address **1033 Fifth Street**		4. Employer phone number **559-324-2725**
5. City **Clovis**	6. State **CA**	7. ZIP code **93612**
8. Who can we contact at this job? **Personnel Office**		
9. Phone number (if different from above)	10. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☐ We do offer coverage. Eligible dependents are:

  ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, www.HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit www.HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) **No** (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Medicare Part D Notice

Important notice from the City of Clovis about your prescription drug coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **the City of Clovis** 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 Clovis has determined that the prescription drug coverage offered by the medical plan 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 Clovis** coverage **will** be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

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 **the City of Clovis** 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 **the City of Clovis** 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, 2024
Name of Entity/Sender:	City of Clovis
Contact-Position/Office:	Personnel Office
Address:	1033 Fifth Street, Clovis, CA. 93612
Phone Number:	559-324-2725

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.

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.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in **the City of Clovis'** 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 **the City of Clovis**' health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in **the City of Clovis'** 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.

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.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 | Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov | KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 | Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 617-886-8102
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp | Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

ACA Disclaimer

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