BENEFITS GUIDE 2024

Explore Your Options

Your Benefits. Your Way.

January 2024 – December 2024

WELCOME

Please take a few minutes and read through our 2024 Benefits Handbook. Despite the challenges of increasing healthcare costs, the Chelan County Benefit program remains stable.

We appreciate the time, effort and support the members of our Benefits Committee provided throughout the year reviewing claims data and benefit information. Their recommendations have been incorporated into the benefits program.

Chelan County offers a menu of plan options for your review and selection. Please review this information carefully. The plan you choose should meet your needs for comprehensive medical and dental insurance. It is our pleasure to offer these plans, and we appreciate your work at Chelan County.

Please remember that our door is always open to receive your comments. We welcome your thoughts and input and thank you for being part of the Chelan County team.

Sincerely,
Chelan County Board of Commissioners

IMPORTANT CHANGES TO 2024

MEDICAL PROGRAMS

Chelan County's medical Plans 2 and 3 are considered "grandfathered plans" under Federal healthcare reform law and therefore do not contain some of the consumer protections that are required in a "non-grandfathered" plan.

The medical program is remaining the same for 2024 with Premera Blue Cross.

Virtual Care – around the clock care by phone, video and text available 24/7, 365 days a year. Care includes: General Medicine, Substance use disorder, Mental Health, 24-hour Nurseline & Specialty Care.

IMPORTANT REMINDERS

Premera offers a 24-Hour Nurse line 1-800-841-8343. The nurses on staff can answer your questions and offer health-related advice.

EAP Program
The Chelan County Employee Assistance Program (EAP) is available through ComPsych at 800-295-9059. The staff at ComPsych are available to help employees who are in need of personal assistance on topics ranging from counseling services to substance abuse issues. Their website is:

www.guidanceresources.com
Web ID: lifehelp
App: GuidanceResources Now

Important Notes: 1) As a political subdivision, Chelan County is exempt from federal ERISA law. 2) This document (Benefit Handbook) is not a Summary Plan Description (SPD) as defined by ERISA. Please review thoroughly the SPD issued by each carrier for the coverage in which you have enrolled. If this Benefit Handbook and/or the SPD are silent as to a particular matter that is addressed in the Master Group Contract, the Master Group Contract will control. If this Benefit Handbook and/or the SPD are in conflict as to a particular matter that is addressed in the Master Group Contract, the Master Group Contract will control. You may request to review or receive a copy of the Master Group Contract at any time by making this request to the Commissioners or the Human Resources Office. If you have questions or comments regarding this, please call Jessica Carr at OneDigital, 888-858-5115 for assistance. 3) While it is hoped that the plans summarized in this Benefit Booklet will continue indefinitely, your employer reserves the right to change or terminate any plan or plans in the future. 4) You must exhaust all claim appeal procedures outlined in the Master Group Contract before pursuing other legal remedies.

BENEFITS OFFERED

Much of the information you need regarding your benefits is contained in this handbook. Enrollment forms for the various programs are available in the Human Resources Office.

BENEFITS START DATE

Benefits begin the first day of the month following employment **or** the first of the month if you are hired on the first. Examples:

- You begin employment on February 17; you are eligible for benefits March 1.
- You begin employment on March 1; you are eligible for benefits March 1. (If you are hired on the 1st, but the first working day falls after a weekend, you still begin benefits the first of the month in which you begin employment).

MEDICAL INSURANCE

Employees may choose from three Preferred Provider Plans (PPO). Plan 2 has a $200 annual deductible and a $20 office visit copay. Plan 3 has a $500 annual deductible and a $30 office visit copay. Plan 4 has a $1,000 annual deductible and a $30 office visit copay.

DENTAL INSURANCE

Delta Dental of Washington is a Preferred Provider Plan (PPO) that covers preventive dental care as well as basic and major dental care. Use "PPO" contracted dentists for the best level of coverage.

LIFE / ACCIDENTAL DEATH INSURANCE

Each employee is provided with a term life and accidental death and dismemberment insurance policy. Benefits are paid for certain loss of limb(s)/eye(s), and the death benefit is doubled for accidental death.

VOLUNTARY LIFE FOR EMPLOYEE AND DEPENDENTS

Newly hired employees have 30 days to purchase, at their own expense, additional term life insurance (up to $100,000) at affordable rates through Mutual of Omaha with no health questions. Those who do not sign up within their initial 30-day eligibility period must be approved after completing a health questionnaire if they wish to obtain coverage at a later date. Coverage is available for both the employee and dependents (spouse and children).

VOLUNTARY LONG TERM DISABILITY INSURANCE

Newly hired employees have 30 days to purchase, at their own expense, a long-term disability policy through Mutual of Omaha that will pay 60% of pre-disability earnings to a maximum of $6,000 per month after 120 days of disability. Those who do not sign up within their initial 30-day eligibility period must fill out a health questionnaire if they wish to obtain coverage at a later date

VOLUNTARY INSURANCE, AFLAC

Employees may purchase, at their own expense, additional insurance products through AFLAC.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Employees may access mental health and chemical dependency assessment, legal consulting, and referrals for adult care, elder care and childcare through ComPsych Guidance Resources at 800-295-9059.

Their website is: www.guidanceresources.com.
Web ID: lifehelp
App: GuidanceResources Now

FLEXIBLE SPENDING ACCOUNTS/PREMIUM CONVERSION PLAN

Employees may set aside pre-tax dollars to pay for unreimbursed medical expenses and/or dependent childcare expenses. In addition, the employee's share of medical and dental insurance premiums will be deducted from pre-tax pay unless you request in writing to the Human Resources Office for your deduction to be taken from after-tax pay.

VEBA

HRA VEBA is a tax-free health savings account that is employer funded for your current and future out-of-pocket medical and retiree health insurance expenses. Eligible employees will be signed up at the time of hire. If you are a current VEBA member, contact HR for questions.

INSTRUCTIONS

Choose the plans in which you wish to participate.
Obtain the enrollment form(s) from the Human Resources Office.
Fill out the enrollment form(s) in full. **Make sure to sign and date all forms and return to the Human Resources Office by December 14th.**

ENROLLMENT AND ELIGIBILITY

Offering a comprehensive and competitive benefits package is one way we recognize your contribution to the success of the organization and our role in helping you and your family to be healthy, feel secure and maintain work/life balance. This enrollment guide has been designed to provide you with information about the benefit choices available to you. Remember, open enrollment is your only opportunity each year to make changes to your elections, unless you or your family members experience an eligible "change in status."

How to Enroll in the Plans

Read your materials and make sure you understand all of the options available.

- Locate your enrollment/change forms.
- Fill out any necessary personal information.
- Make your benefit choices.
- If you have questions or concerns, please contact your HR department.

Whom Can You Add to Your Plan?

Eligible:

- Legally married spouse or domestic partner
- Natural or adopted children up to age 26, regardless of student and marital status
- Children under your legal guardianship
- Stepchildren
- Children under a qualified medical child support order
- Disabled children 19 years or older
- Children placed in your physical custody for adoption

Ineligible:

- Divorced or legally separated spouse
- Common law spouse, even if recognized by your state
- Foster children
- Sisters, brothers, parents or in-laws, grandchildren, etc.

Change in Status

Generally, you may enroll in the plan, or make changes to your benefits, when you are first eligible. However, you can make changes/enroll during the plan year if you experience a change in status. As with a new enrollee, you must submit your paperwork within 30 days of the change, or you will be considered a late enrollee.

Examples of changes in status:

- You get married, divorced or legally separated
- You have a baby or adopt a child
- You or your spouse takes an unpaid leave of absence
- You or your spouse has a change in employment status
- Your spouse dies
- You become eligible for or lose Medicaid coverage
- Significant increase or decrease in plan benefits or cost

Did you know?

Open Enrollment is the only chance to make changes, unless you experience a "change in status."

CUSTOMER SERVICE

COVERAGE	GROUP NUMBER	CUSTOMER SERVICE	WEB ADDRESS
MEDICAL / VISION			
Premera Blue Cross 24-Hour Nurse Line Case Management	1018510	800-722-1471 800-841-8343 800-344-2227	www.premera.com
DENTAL			
Delta Dental of Washington	698	800-554-1907	www.deltadentalwa.com
LIFE AND AD&D			
Mutual of Omaha	GLUG-62S5	800-877-5176	www.mutualofomaha.com
VOLUNTARY LONG-TERM DISABILITY			
Mutual of Omaha	TBD	800-877-5176	www.mutualofomaha.com
VOLUNTARY BENEFITS			
AFLAC Kendra Hinckley	0EKR9	509-387-1557 603-250-2788 Fax	www.aflac.com kendra_colter@us.aflac.com
EMPLOYEE ASSISTANCE PROGRAM (EAP)			
ComPsych Guidance Resources	ZC2317W	800-295-9059	www.guidanceresources.com
SECTION 125 PLAN			
AFLAC WageWorks	n/a	800-462-3522	www.aflac.com www.MyFlexOnline.com
VEBA			
Richard Dickman Technical Support Account information / claims: AJG		800-888-VEBA 888-659-8828	Rich_Dickman@ajg.com www.hraveba.org
PACIFIC NORTHWEST WELLNESS CENTER (formerly Redimedi)			
Wenatchee Location	230 Grant Road, Ste B2 East Wenatchee, WA 98802	509-888-6334	www.pnwwellnesscenter.com
BROKER CONTACTS			
Jessica Carr Senior Benefits Consultant 253-691-3327 jcarr@onedigital.com		Anissa Keeler Senior Account Manager 206-566-3628 anissa.keeler@onedigital.com	
HR CONTACTS AT CHELAN COUNTY			
Margaret Walters HR Manager 509-667-6397 margaret.walters@co.chelan.wa.us		Yvonne Mayorga HR Generalist 509-667-6311 Yvonne.mayorga@co.chelan.wa.us	
Rosalinda Barragan HR Asst / Civil Service Examiner 509-667-6804 roaslinda.barragan@co.chelan.wa.us			

2024 MONTHLY RATES

PREMERA BLUE CROSS – PLAN 2 Premera "Heritage" Doctor and Hospital Network $200 deductible, then 80% coverage until you have $2,000 out-of-pocket, then 100% coverage $20 office copay (not subject to deductible) Rx $10 generic / $20 brand name / $40 non-preferred brand name	
Employee (or LEOFF II)	$972.43
Employee & Spouse	$1,918.43
Employee & Children	$1,429.87
Employee, Spouse and Children	$2,332.07

PREMERA BLUE CROSS – PLAN 3 Premera "Heritage" Doctor and Hospital Network $500 deductible, then 80% coverage until you have $3,000 out-of-pocket, then 100% coverage $30 office copay (not subject to deductible) Rx $10 generic / $25 brand name / $50 non-preferred brand name	
Employee (or LEOFF II)	$907.31
Employee & Spouse	$1,659.67
Employee & Children	$1,237.01
Employee, Spouse and Children	$2,017.50

PREMERA BLUE CROSS – PLAN 4 Premera "Heritage" Doctor and Hospital Network $1,000 deductible, then 80% coverage until you have $3,000 out-of-pocket, then 100% coverage $30 office copay (not subject to deductible) Rx $10 generic / $25 brand name / $50 non-preferred brand name	
Employee (or LEOFF II)	$857.40
Employee & Spouse	$1,568.39
Employee & Children	$1,168.98
Employee, Spouse and Children	$1,906.54

DELTA DENTAL OF WASHINGTON DELTA DENTAL PPO Network	
Employee	$56.32
Employee & Spouse	$117.09
Employee & Children	$125.13
Employee, Spouse and Children	$185.89

The rates shown in this guide are illustrative only. To the extent the rates contained herein differ from those in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the rates in the underlying insurance documents will govern in all cases.

SUMMARY OF MEDICAL BENEFITS

	PREMERA BLUE CROSS PLAN 2 *Active employees and Retirees without Medicare*	PREMERA BLUE CROSS PLAN 3	PREMERA BLUE CROSS PLAN 4
PLAN FEATURES			
Plan Type	**Preferred Provider Organization (PPO)** To receive the highest level of benefits you must use preferred providers from the **Premera Blue Cross Heritage Network**	**Preferred Provider Organization (PPO)** To receive the highest level of benefits you must use preferred providers from the **Premera Blue Cross Heritage Network**	**Preferred Provider Organization (PPO)** To receive the highest level of benefits you must use preferred providers from the **Premera Blue Cross Heritage Network**
Physician Network in WA	Heritage Network	Heritage Network	Heritage Network
Deductible Per Person Per Family	 $200 $600	 $500 $1,500	 $1,000 $3,000
Out-Of-Pocket Expense Maximum Per Person Per Family	 $2,000 $6,000	 $3,000 $9,000	 $3,000 $9,000
If you use a non-contracted provider (Preventive Care and Transplant related care are not covered out- of-network)	Covered at 60% of the Premera Blue Cross allowed charge (services rendered by a non-preferred provider do not apply towards the calendar year out-of-pocket maximum)	Covered at 60% of the Premera Blue Cross allowed charge (services rendered by a non-preferred provider do not apply towards the calendar year out-of-pocket maximum)	Covered at 60% of the Premera Blue Cross allowed charge (services rendered by a non-preferred provider do not apply towards the calendar year out-of-pocket maximum)
Dependent Children Coverage	Children covered to age 26	Children covered to age 26	Children covered to age 26

Prior Authorization is required on services including planned hospital admissions, planned outpatient procedures, non-emergency transport, advanced imaging such as MRIs and CT scans, transplants, injectable medications, prosthetics and orthotics, reconstructive surgery, home medical equipment costing $500 or more.

SUMMARY OF MEDICAL BENEFITS (continued)

	PREMERA BLUE CROSS PLAN 2 *Active employees and Retirees without Medicare*	PREMERA BLUE CROSS PLAN 3	PREMERA BLUE CROSS PLAN 4
PHYSICIAN SERVICES			
Physician Office Visits	$20 copay, deductible waived	$30 copay, deductible waived	$30 copay, deductible waived
Visits to Specialists (No Referral Required)	$20 copay, deductible waived	$30 copay, deductible waived	$30 copay, deductible waived
Lab, X-ray, Diagnostic Services	Covered at 80%, after deductible (mammograms and colonoscopies 80%, deductible waived)	Covered at 80%, after deductible (mammograms and colonoscopies 80%, deductible waived)	Covered at 80%, after deductible (mammograms and colonoscopies 80%, deductible waived)
Preventive Care Well Baby Care Routine Physical	$20 copay, deductible waived (mammograms and colonoscopies covered in full)	$30 copay, deductible waived (mammograms and colonoscopies covered in full)	Covered in full
Urgent Care Facility	$20 copay, deductible waived	$30 copay, deductible waived	$30 copay, deductible waived
Spinal Manipulation (Chiropractic Care)	$20 copay, 24 visit maximum per calendar year, deductible waived	$30 copay, 24 visit maximum per calendar year, deductible waived	$30 copay, 24 visit maximum per calendar year, deductible waived
Naturopath	$20 copay, deductible waived	$30 copay, deductible waived	$30 copay, deductible waived
Acupuncture	$20 copay, 24 visit maximum per calendar year, deductible waived	$30 copay, 24 visit maximum per calendar year, deductible waived	$30 copay, 24 visit maximum per calendar year, deductible waived
HOSPITAL SERVICES			
Semi-Private Room	80% after deductible	80% after deductible	80% after deductible
Outpatient Surgery	80% after deductible	80% after deductible	80% after deductible
World Wide Emergency Care	80% after deductible	80% after deductible	80% after deductible
Ground Ambulance	80% after deductible	80% after deductible	80% after deductible
Air Ambulance (when medically necessary)	80% after deductible	80% after deductible	80% after deductible
OTHER SERVICES			
Maternity Care (Employee or spouse only)	Covered as any other condition	Covered as any other condition	Covered as any other condition
Routine Immunizations	Covered at 100%	Covered at 100%	Covered at 100%
Allergy Treatment Antigen Administration	80% after deductible	80% after deductible	80% after deductible

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

SUMMARY OF MEDICAL BENEFITS (continued)

	PREMERA BLUE CROSS PLAN 2 *Active employees and Retirees without Medicare*	PREMERA BLUE CROSS PLAN 3	PREMERA BLUE CROSS PLAN 4
MENTAL HEALTH			
Inpatient	**80% after deductible**	**80% after deductible**	**80% after deductible**
Outpatient	$20 copay	$30 copay	$30 copay
Chemical Dependency			
Inpatient	80% after deductible	80% after deductible	80% after deductible
Outpatient	$20 copay	$30 copay	$30 copay
Outpatient Physical, Speech, Occupational and Massage Therapy	$20 copay, 45 visit limit	$30 copay, 45 visit limit	$30 copay, 45 visit limit
Diabetic Supplies	Covered under Rx	Covered under Rx	Covered under Rx
SUPPLEMENTAL BENEFITS			
Durable Medical Equipment	80% after deductible	80% after deductible	80% after deductible
Temporomandibular Joint Dysfunction (TMJ)	Covered as any other condition to $1,000 per year, $5,000 per lifetime	Covered as any other condition to $1,000 per year, $5,000 per lifetime	Covered as any other condition to $1,000 per year, $5,000 per lifetime
Vision Exam One per calendar year	$20 copay, deductible waived	$30 copay, deductible waived	$30 copay, deductible waived
PRESCRIPTION DRUGS			
Retail (30-day supply)			
Generic	$10 copay	$10 copay	$10 copay
Preferred Brand	$20 copay	$25 copay	$25 copay
Non-Preferred Brand	$40 copay	$50 copay	$50 copay
Mail Order (90-day supply)			
Generic	$20 copay	$20 copay	$20 copay
Preferred Brand	$40 copay	$50 copay	$50 copay
Non-Preferred Brand	$80 copay	$100 copay	$100 copay

You may search for providers online at **www.premera.com**.

This is a brief summary of medical benefits provided for the convenience of Chelan County employees and their dependents. If the information contained in this summary is incorrect, the Master Contract will control.

MEDICARE ELIGIBLE RETIREES

Effective January 1st, 2024 the Chelan County Retiree with Medicare Plan (age 65+) will be changing from the current Premera Plan to a Premera Blue Cross Supplement Plan G. Please see the following information.

Plan	Premera Blue Cross Medicare Supplement Plan G
Monthly cost est.	$207
Deductible	$226 for doctor services, no deductible for all other covered services
Coverage	After deductible plan pays 100%
Out-of-pocket Maximum	$226 deductible for doctor services
Prescriptions	Must purchase a Medicare Part D prescription drug plan – cost ranges between $13 to $74 per month
Pharmacy Benefits	Benefits based upon plan elected.

Medicare Part D plans are suited for your specific prescription drug needs. See www.medicare.gov click on "Find health & drug plans/Find Plans Now" enter your home zip code and select "Drug Plan (Part D)".

Contact your local, licensed Medicare agent, or Berg Benefits in-house Medicare Advisor Robin Marcello directly for Premera Blue Cross Supplement Plan G, and Medicare Part D Prescription Drug Plan options.

Robin Marcello
Medicare Specialist & Benefits Advisor
Direct: (253) 987-1004
Office: (877) 466-1999
RMarcello@RedQuote.com

YOU MUST HAVE MEDICARE PART A, AND MEDICARE PART B TO PURCHASE A MEDICARE SUPPLEMENT

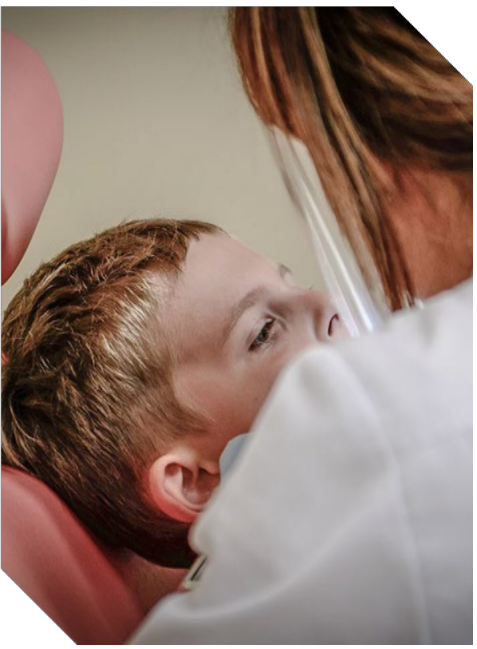
EARLY RETIREE INFORMATION

All retirees upon termination of employment qualify for COBRA Continuation Coverage or enrollment on the retiree plans. If an employee retires before Medicare eligibility, the plan benefits for the early retiree plan are the same as Plan 2.

IMPORTANT: If you do not choose to enroll at the time of retirement, there is no future opportunity to enroll.

RETIREE WITHOUT MEDICARE – SAME AS PLAN 2	
Retiree	$1,025.11
Retiree & Spouse	$2,169.48
Spouse only	$1,144.37
Retiree & Children	$1,402.52
Retiree, Spouse and Children	$2,905.86

DENTAL PLAN



Delta Dental of Washington provides coverage in all 50 states. If your dentist is a Delta Dental of Washington Member Dentist or a Delta Dental of Washington Preferred Dentist, your dentist will submit claims directly to Delta Dental of Washington. If you choose a non-member dentist, you may be responsible for submitting claims to Delta Dental of Washington. Claim payments for non-member dentists will be made based on a usual and customary fee schedule.

Delta Dental of Washington		
Name of Plan	Delta Dental PPO	
Class	**PPO Contracted Providers**	**Delta Premier or Non-Participating**
Preventive	100%	80%
Basic Restorative	80%	70%
Major Services	50%	40%
Orthodontia	50%	50%
Plan Details		
Endodontics/Periodontics: Basic or Major	basic	basic
Orthodontics (Adult/Children)	both	both
Dependent Children Coverage	to age 26	
Deductible	no deductible	
Plan Maximums	waived for preventive services	
Calendar Year Max	$2,000	$2,000
Ortho Lifetime Max	$1,500	$1,500

Did you know?

One can of soda is the amount of sugar recommended for three days for a child. Sugary Sodas are a major risk factor for tooth decay*

If your dental work will be extensive (in excess of $500), ask your dentist to complete and submit a standard ADA claim form to Delta Dental of Washington for a predetermination. This will allow you to know in advance exactly what procedures are covered, the amount Delta Dental of Washington will pay toward the treatment, and your financial responsibility.

Source: American Dental Association (ADA)

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EMPLOYER PAID LIFE AND AD&D INSURANCE PLAN

Mutual of Omaha	
Life Benefit – Sheriff / Jail	$50,000
Life Benefit – All Other County Employees	$10,000
Dependents (Spouses & Children to age 26)	$2,000
AD&D	Equal to Life Benefit
Age Reduction Schedule	Reduce to 65% at age 65, to 45% at age 70

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VOLUNTARY LIFE AND AD&D INSURANCE PLAN

Voluntary term life insurance with accidental death insurance is purchased at your own expense through payroll deduction. It is a convenient and affordable way to supplement your family's life insurance protection.

Mutual of Omaha	
Employee Life/AD&D Benefit	5x annual salary up to $500,000 in increments of $10,000
Employee Guaranteed Amount	$100,000
Spouse Life/AD&D Benefit	50% of employee benefit up to $100,000 in increments of $5.000
Spouse Guaranteed Amount	25,000
Child Life Amount	$10,000 per child in increments of $1,000
Child Guaranteed Amount	$10,000
Age Reduction Schedule	to 65% at age 70, to 45% at age 75
Accelerated Death Benefit	If you become terminally ill, you may be able to receive a portion of your life coverage benefit as a lump sum
Conversion	Included

AGE	EMPLOYEE RATE (rate per month per $10,000 of coverage)	SPOUSE RATE (rate per month per $5,000 of coverage)
0-29	$1.41	$.74
30-34	$1.54	$.82
35-39	$1.82	$.96
40-44	$2.62	$1.39
45-49	$4.24	$2.25
50-54	$6.80	$3.60
55-59	$10.44	$5.54
60-64	$16.10	$8.54
65-69	$28.63	$15.20
Children	$0.13 (per thousand per child)	

NOTE: If you do not enroll when initially eligible, you will be required to submit evidence of good health if you wish to purchase coverage at a later date.

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

LONG TERM DISABILITY INSURANCE

Voluntary Long-Term Disability

Mutual of Omaha	
Benefit	60%
Maximum Monthly Benefit	$6,000
Elimination Period	120 days
Own Occupation Period	24 months
Pre-existing Conditions	If treated with in 90 days prior to coming on the plan, then the benefit will become effective after 12 months
Duration of Benefits	To normal Social Security Retirement Age

COST CALCULATION WORKSHEET – VOL. LTD

1. Enter your monthly earnings: $ _____
2. Find the rate factor based on your age: $ _____
3. Divide line 1 by 100, then multiply by the number on line 2. This is your monthly cost: $ _____

For more detailed information contact the Human Resources Office.

Rate per $100 based upon your age:

>24	$0.07
25-29	$0.11
30-34	$0.15
35-39	$0.20
40-44	$0.27
45-49	$0.39
50-54	$0.60
55-59	$0.75
60-64	$0.80
65-69	$0.84
70-99	$0.86

Did you know?

Of today's 20-year-olds, just over 1 in 4 will become disabled before they retire.*

**Source:* Council For Disability Awareness. "Disability statistics." July 3, 2013. Web Accessed November 10, 2014.

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WASHINGTON STATE PAID FAMILY MEDICAL LEAVE (WA PFML)

Washington Paid Family and Medical Leave is a mandatory statewide insurance program that provides Washington employees paid time off to give or receive care. After a **7-day** elimination period from the date of disability, employees are eligible to receive up to **12 weeks** of paid leave, 16 weeks if multiple events are experienced**.**

The premium is 0.74% of employee wages and is shared between employer and employee through payroll deductions. Benefit is a calculated percentage of the employee's gross wages with a weekly benefit from $100-$1,427.

When you take paid leave, you will receive up to 90 percent of your weekly pay—up to a maximum of $1,427 a week.

When you can take leave:

There are four types of paid leave available. Each one is related to a different type of "qualifying event"—the thing that happens to you or a family member that qualifies you for paid leave.

1) **Medical Leave**
2) **Family Leave**
3) **Military Family Leave**
4) **Parental Leave**

To apply, go to https://paidleave.wa.gov/
- Make sure you give your employer at least 30 days notice
- Have Proof of ID ready
- Documentation supporting the type of leave you are taking

Employees are responsible for notifying their employer and filing a claim with the state. If you need information about your employment history, please see HR.

FLEXIBLE SPENDING ACCOUNTS (FSA)

PREMIUM CONVERSION PROGRAM

The premium conversion program allows employees to avoid Social Security and federal income tax on monthly amounts that are payroll deducted for group insurance (medical, dental, vision and life) premiums. There are no forms to fill out. Participation in the program is automatic unless you request in writing not to participate in the premium only program (contact the Human Resources Office for a form to decline participation).

MEDICAL & DENTAL REIMBURSEMENT ACCOUNT PROGRAM (HEALTH FSA)

The medical and dental reimbursement account program lets you use pre-tax dollars (up to $3,200) to pay medical and dental care expenses that you have paid out-of-pocket. Your contribution will be deducted from your pre-tax salary in equal amounts for the plan year. You may submit claims for reimbursement at anytime once the expense has been incurred.

DEPENDENT CARE REIMBURSEMENT ACCOUNT PROGRAM (DEPENDENT CARE FSA)

The dependent day care account program lets you use pre-tax dollars (up to $5,000) to pay daycare expenses. Your contribution will be deducted from your pre-tax salary in equal amounts for the plan year. The following example illustrates the benefit of using a flexible reimbursement account.

Without Flexible Reimbursement Account		With Flexible Reimbursement Account	
Gross Monthly Salary	$2,500	Gross Monthly Salary	$2,500
Income Tax @ 15% plus		Qualifying Insurance Premiums	-$100
FICA @ 7.65%	-$566	Qualifying Health Care Expenses	-$100
		Qualifying Dependent Care Expenses	- $350
Net Income (after taxes)	$1,934	Gross Taxable Income	$1,950
Qualifying Insurance Premiums	-$100	Income Tax @ 15% plus	
Qualifying Health Care Expenses	-$100	FICA @ 7.65%	-$441
Qualifying Dependent Care Expenses	-$350		
Take Home Pay	$1,384	Take Home Pay	$1,509

As you can see, with $550 in monthly qualified expenses, you would have an extra $125 each month ($1,500 per year) of take-home pay, saving dollars you would otherwise pay in taxes.

ELIGIBLE EXPENSES

The expenses covered by, but not paid by insurance, such as the deductible, coinsurance (the percentage of charges not covered) within the plan year, as well as:
Non-reimbursed medical expenses for preventive, diagnostic, and therapeutic care
Medicine or other drugs prescribed by a medical doctor
Non-reimbursed dental expenses for preventive, diagnostic endodontic, orthodontic and therapeutic care
Medicine or other drugs prescribed by a dentist
Non-reimbursed vision expenses

NON-ELIGIBLE EXPENSES

Expenses reimbursed through any insurance policy or plan
Expenses incurred before you enroll in the plan
Expenses you claim as a deduction or credit for income tax purposes

FLEXIBLE SPENDING ACCOUNTS (FSA) continued

PLAN RULES

The IRS requires that you use all the money you contribute to your account or forfeit the remainder at the end of the plan year.*

Expenses incurred by you, or any covered dependent are eligible for reimbursement. Expenses must be incurred during the plan year. You have 60 days from the end of the plan year to submit claims. Up to *$500 of any amount remaining unused in the Medical & Dental Reimbursement account will carryover into the next plan year.

MAKING CHANGES

The amount you set aside monthly will be effective for the entire plan year. The plan year is January 6th through January 5th.

How you enroll on the benefit plans with spouse or children may be changed only if you apply within 31 days of a change in family status. These changes include: marriage, legal separation or divorce, birth, adoption or change in custody of a minor child, change in your spouse's employment status, death of your spouse or child, change between full-time and part-time status by an employee or spouse, unpaid leave of absence by employee or spouse, or significant change in coverage of employee or spouse due to spouse's employment.

Unless you have a change in family status, you cannot make changes until the next open enrollment.

MAKING CLAIMS

When you incur an eligible expense during the year, file a request for reimbursement form (available in the Human Resources office). You can also make claims online at www.MyFlexOnline.com. You will need to enclose or attach proof of service, such as an explanation of benefits that contains date of service, description of service, provider's name, cost and name of person receiving care.

DEPENDENT CARE SPENDING ACCOUNT

The Dependent Care Spending Account is a tax-effective way to pay childcare or other dependent care services that enable you or you and your spouse to work outside the home.

You may use this account to pay for eligible day care expense incurred for:
A child up to age 13 for whom you claim a deduction on your income tax form, or
A spouse or disabled dependent age 13 or older (your parent, for instance) who is physically or mentally incapable of self-care, who normally spends at least eight hours in your home each day, and for whom you pay more than half the cost of support.

Eligible day care expenses include costs for nursery schools, day care providers, babysitters and other types of day care. A provider cannot be another dependent of yours, such as an older child. Nursery schools and day care centers must comply with state and local regulations if their expenses are to be eligible for reimbursement.

You may set aside up to $5,000 each plan year in your Dependent Care Spending Account through automatic payroll deductions or $2,500 if you are married filing a separate return.

DEPENDENT CARE SPENDING ACCOUNT VS. THE DEPENDENT CARE TAX CREDIT

For many employees, the Dependent Care Spending Account is a better method than taking the dependent care tax credit on the income tax return. Generally, the tax credit is more beneficial if your adjusted gross income is less than $24,000.

GOVERNMENT RULES ON UNUSED FUNDS

Federal tax law says that any money left in your account at the end of the plan year must be forfeited. Other than up to $500 of any amount remaining unused in the Medical & Dental Reimbursement account which will carryover into the next plan year.

VEBA – HRA Plan

WHAT IS THE HRA VEBA PLAN?

The HRA VEBA Plan is a pre-retirement and post-retirement health reimbursement plan. The HRA VEBA Plan enables your employer to make tax-free contributions into an HRA VEBA Trust account on your behalf. The Plan is available to employees of counties, cities, towns and special purpose districts in Idaho, Oregon and Washington.

WHAT IS A VEBA AND WHAT ARE THE TAX OBJECTIVES OF THE PLAN?

A VEBA is a tax-exempt trust authorized by Internal Revenue Code Section 501(c)(9). The tax objectives of this type of plan are to enable your employer to make tax-free deposits on your behalf to the Plan, for your account to be credited with tax-free investment earnings, and to enable you to obtain tax-free reimbursements for your medical expenses and insurance premium payments. HRA VEBA contributions are not W-2 reportable earnings.

WHY SHOULD I PARTICIPATE IN THE HRA VEBA PLAN?

An HRA VEBA account provides a tax-free source of funds to pay for the cost of health care expenses for you, your spouse, and your qualified dependents. Your HRA VEBA account may be used to pay any qualified pre or post-retirement medical, dental, or vision out-of-pocket expenses (deductibles, co-payments, co-insurance, etc.), plus post-retirement medical, dental, or vision insurance premiums, Medicare Part B premiums, Medicare supplement plans, and tax qualified long term care insurance premiums.

HOW DO I BECOME A PARTICIPANT IN THE PLAN?

When you are eligible, you will receive an email notifying you of your enrollment following completion of your new hire paperwork. After the first contribution is made you will be eligible to access your account online to complete your enrollment. Contact Human Resources if you have questions about your eligibility, or when you will have access to the HRA VEBA contributions.

NOTE: Employees not participating in a County sponsored medical plans must be enrolled in a qualified medical plan in order to have access the VEBA funds. If not in a qualified medical plan, the VEBA contribution is deposited into an account that would be accessible post-employment with the county.

PACIFIC NORTHWEST WELLNESS CENTER

Services offered at Pacific Northwest Wellness Center Integrative Direct Primary Care practice:

- Health Promotion, disease prevention, health maintenance, diagnosis and treatment of acute and chronic illnesses for family
- Women's Health: including specialty in hormone related issues
- Men's health: including hormone and thyroid related issues
- RubiconMD www.rubiconmd.com: eConsults that connect our clinicians to over 100 specialists from Harvard, Yale, Standford. Consults are completed within 2 hours on average and this service has resulted in a 75% reduction of visits for our members to specialist here locally. We have completed over 130 consults to date savings our members the average cost of $375 for a visit to the specialist.
- In-house phlebotomy with access to Cleveland Hearts Labs that provide wholesale labs at a fraction to labs done at the local Confluence labs.
- CDL/DOT physicals
- Certified Drug Screenings
- Pre-employment screenings
- Treatment and management of work-related injuries
- In-house physical therapy when needed for $80 per visit
- Food allergy testing
- In-house CIMT (carotid intima media thickening) for primary and secondary CVD prevention, $170
- In-house ECHO twice yearly with Cardiology read, $360
- In-house Plethysmography (PTG) and Photoplethysmography (PPG) for primary and secondary CVD prevention one to three times annually (No cost to member)
- Vaccines (Hep A, Hep B, Tetanus, Dtap) with access to other vaccines as needed
- In-home Sleep Study through Blackstone Medical Services
- 24/7 Physical/NP access via secure HIPPA text and email system
- Access to lower cost imaging services through Inland Imagine and Bellevue Medical Imaging as well as on-line access to the images through these two centers of excellence. We also have access to imaging services through the Foot & Ankle Center of Wenatchee

PNWC
PACIFIC NORTHWEST WELLNESS CENTER

WENATCHEE LOCATION
230 Grant Road, Suite B2
East Wenatchee, WA 98802
(509) 888 – 6334
www.pnwwellnesscenter.com

The benefit plan information shown in this guide is illustrative only. This information is not intended to be exhaustive nor should any discussion or opinions be construed as professional advice.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Chelan County Employee Assistance Program (EAP) is available through ComPsych at:

800-295-9059

The ComPsych Guidance Resources Employee Assistance Program (EAP) is a confidential service provided to help employees with personal difficulties such as emotional problems, substance abuse issues, relationship and family crisis, and legal and financial worries.

CONFIDENTIAL CONSULTATION ON PERSONAL ISSUES

Your EAP is a no-cost, confidential assistance program to help address the personal issues you and your dependents are facing. This service, staffed by experienced clinicians, is available by phone 24 hours a day, seven days a week. A Guidance Consultant will refer you to a local consultant or to resources in your community.

LEGAL INFORMATION AND RESOURCES

When a legal issue arises, attorneys are available to provide confidential support with practical, understandable information and assistance. If you require representation, you can also be referred to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter.

INFORMATION, REFERRALS AND RESOURCES FOR WORK-LIFE NEEDS

Whether you are a new parent, a caregiver for an elder, sending a child off to college, buying a car or doing home repairs, you're bound to have questions or need resource referrals. Work-life specialists will help you sort out the issues and provide you with information based on your specific criteria. You'll receive a personalized reference package containing helpful resources and literature, covering areas such as finding child or elder care, finding pet care, relocating to a new city, home repair, planning for college, and purchasing a car.

VOLUNTARY INSURANCE BENEFITS

AFLAC

The following benefits are available for employees to purchase, at their own expense, through payroll deduction:

Accident Indemnity Insurance

Accident Policy provides benefits to you when you are involved in an accident on OR off the job. The policy provides initial diagnosis, ambulance, hospitalization benefits, a yearly wellness benefit and much more.

Cancer Indemnity Insurance

Maximum Difference Policy provides a first occurrence benefit, initial treatment benefit, hospitalization, surgical benefits, reconstructive surgery, travel expenses, lodging expenses, in-home, hospice and extended care benefits, a yearly wellness benefit and more. This is a catastrophic policy.

Disability Income Protector

AFLAC's Disability Income Protector is short-term disability insurance designed to fill-in-the-gap of your long term disability insurance. Benefit periods of 3, 6, 9 or 12 months are available, depending on your need. This policy will provide maternity benefits. Short-term disability is an asset protector in the event of a disability providing you with funds to help you maintain your lifestyle until you are able to return to work.

Hospital Indemnity Protection

Hospital Indemnity Protection policy provides benefits when you are admitted to the hospital for accidents or illness. It also provides benefits for day surgeries on an outpatient basis, specific surgical benefit, diagnostic exams and rehabilitation benefits.

Dental Insurance

Supplemental Dental Policy enhances your current dental policy with an additional $1,200 in benefits per year for everyone included on the policy.

For information contact Kendra Hinckley at kendra_colter@us.aflac.com or 509-387-1557.

ADDITIONAL COVERAGE OPTIONS

INDIVIDUAL MEDICAL COVERAGE

In some instances, you may be able to insure your dependent spouse or domestic partner and/or dependent children for medical coverage less expensively under an individual policy. If you would like to review available options contact OneDigital for individual quoting services.

APPLE HEALTH FOR KIDS PROGRAM

In Washington State, a program is offered to provide subsidized health insurance coverage to children under age 19, and qualification is based on the family income level. The program is funded by federal tax dollars, and almost all states have taken advantage of these dollars and developed similar programs.

Qualification for the Apple Health for Kids program is as shown below:

The Family's Income is:	Up to 210% of "federal poverty level"	260% of "federal poverty level"	312% of "federal poverty level"
Examples of Qualifying Income Levels	For a family of 2 people, 210% of federal poverty level is $3,534 monthly. For a family of 4, 210% is $5,375 monthly.	For a family of 2 people, 260% of federal poverty level is $4,355 monthly. For a family of 4, 260% is $6,625 monthly.	For a family of 2 people, 312% of federal poverty level is $5,210 monthly. For a family of 4, 312% is $7,925 monthly.
Monthly Cost to the Family	Free	$20 per child per month ($40 per month maximum).	$30 per child per month ($60 per month maximum).

Notes:

Income levels are determined by the state and adjust each year on April. 1st.

A pregnant woman counts as a family size of two. Other programs with different eligibility requirements are available for families and pregnant women. Call toll-free 877-543-7669 to find out more. If you have questions regarding Apple Health for Kids and other state programs you might qualify for, please call **877-543-7669**.

Find doctors, dentists and specialists who accept Medicaid at:
https://fortress.wa.gov/hca/p1findaprovider/

1) Select County or City then select from the dropdown list.
2) Enter the provider's name and/or specialty.

IMPORTANT DISCLOSURES

ERISA: Chelan County's benefit plans are exempt from ERISA. ERISA is the federal legislation governing employee welfare benefit plans, but **does not** apply to any benefit plan established or maintained by the government or political subdivision of any state, including Chelan County's benefit plans. Any Chelan County benefit plan document that references ERISA is an unintended error and does not create an ERISA plan or ERISA obligation.

"Grandfathered Health Plan": Chelan County believes benefit plan 2 and 3 coverage are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the plan might not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Chelan County Human Resources.

Plan Administrator Has Final Decision Making Authority: The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion.

Benefit Handbook, SPD and Master Contract: This Benefit Handbook is not a Summary Plan Description (SPD). Please review thoroughly the SPD issued by each plan for the coverage in which you have enrolled. If this Benefit Handbook and/or the SPD are **silent** as to a particular matter that is addressed in the Master Contract, the Master Contract will control. If this Benefit Handbook and/or the SPD are in **conflict** as to a particular matter that is addressed in the Master Contract, the Master Contract will control. You may request to review or receive a copy of the Master Contract at any time by making a request to Chelan County Human Resources.

Plan Changes and Termination: While it is hoped that the plans summarized in this Benefit Booklet will continue indefinitely, your employer reserves the right to change or terminate any plan or plans in the future.

Claim Appeals: You must exhaust all claim appeal procedures outlined in the Master Group Contract before pursuing other legal remedies.

The benefit plan information shown in this guide is illustrative only. This information is not intended to be exhaustive nor should any discussion or opinions be construed as professional advice.

IMPORTANT DISCLOSURES continued

Family and Medical Leave Act

NOTIFICATION

The Family and Medical Leave Act of 1993 (FMLA) is a federal law that became effective on August 5, 1993, for most companies and nonprofit organizations with 50 or more employees.

FMLA applies to all employees who have:

- 12 months of employment with the company *and*
- 1,250 hours or more of service in the preceding 12 months.

FMLA provides 12 weeks of unpaid leave in any 12-month period for the following reasons:

- To care for oneself, a child, spouse, or parent with a “serious health condition”, or "covered service member" who is injured in the line of duty;
- To the immediate family members (spouses, children, or parents) of military personnel or reservists who have "any qualifying exigency" arising out of the service member's active duty or call to active duty in support of a contingency operation.
- Birth, adoption or placement of a child for foster care.

A SERIOUS HEALTH CONDITION IS DEFINED AS

- One that requires continuing treatment from a health care provider.
- Conditions that require an absence from work or regular daily activities for more than 3 days.
- Treatment for pregnancy and certain chronic conditions such as diabetes and asthma even though treatment may last less than three days.
- Conditions and medical treatments that are not ordinarily incapacitating on a day-to-day basis such as chemotherapy and radiation treatment, kidney dialysis, and physical therapy for severe arthritis.
- Mental illness may qualify.
- Specifically excluded are common colds, flu, upset stomach, routine dental problems and stress.

EMPLOYEE RESPONSIBILITIES

- Provide a 30-day notice for foreseeable leaves for birth, adoption, foster placement, or planned medical treatment.
- Continue to pay any required health plan contributions.

IT IS IMPORTANT TO REMEMBER

- With employer’s approval, leave may be taken intermittently or by working a reduced week. However, an exception exists for an employee or family member’s serious health condition whereby leave is taken whenever medically necessary.
- An employer is allowed to substitute an employee’s accrued paid leave for any of the 12-week period.
- The employer is allowed to recover the cost of health benefits paid during the leave if the employee does not return to work.
- During the leave, the employee is ineligible for unemployment compensation.

IMPORTANT DISCLOSURES continued

COBRA Information

If you enroll yourself and any dependents in medical and/or dental coverage, you will be mailed an Initial Notice of COBRA Rights by your employer. **Both employee and spouse (if married) should carefully read through this information.** Should any of the following qualifying events occur while you are an active employee, you will be offered continued coverage rights through Federal COBRA law:

1. Termination of employment (for reasons other than gross misconduct), 18 months of continued coverage.
2. A reduction in your hours of employment; or
3. You are a retiree and your employer has filed for reorganization under Chapter 11 of the Bankruptcy Code, 18 months of continued coverage.

If you are the spouse or dependent child of an employee enrolled in a group medical, dental, and vision plans, you have the right to choose continuation of coverage for yourself if you lose group coverage for any of the following reasons:

1. Termination of your spouse's employment (for reasons other than gross misconduct), 18 months of continued coverage.
2. Death of your spouse, 36 months of continued coverage
3. Divorce or legal separation from your spouse, 36 months of continued coverage
4. Your spouse becomes eligible for Medicare (resulting in the loss of dependent coverage under this plan), 36 months of continued coverage.
5. Your retired spouse's employer files for Chapter 11 reorganization, 18 months of continued coverage.
6. Your child ceases to be a dependent or attains the maximum age allowed by the carrier, 36 months of continued coverage.
7. Your spouse's hours of employment are reduced, 18 months of continued coverage.

REQUIRED NOTICES

Newborn 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 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 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully. As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits: 1. All stages of reconstruction of the breast on which the mastectomy has been performed: 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3. Prostheses and treatment of physical complications of the mastectomy , including lymphedemas. Health plans must provide coverage of mastectomy related benefits in a manner to determine in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and insurance amounts that are consistent with those that apply to other benefits under the plan.

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, 2021. 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
https://dhcs.ca.gov/HIPP
Phone: 916-445-8233
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
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext. 2131

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

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

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: http://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: http://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

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

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/oii/hipp.htm
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/
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
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid
Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

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

RHODE ISLAND – Medicaid
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: 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: 1-887-543-7669

VERMONT - Medicaid
Website: http://greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: http://www.coverva.org/en/famis-select
https://www.coverva.org/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
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p10095,htm
Phone 1-800-362-3002

WYOMING - Medicaid
Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

HIPAA Notice

HIPAA Privacy Notices

HIPAA requires group health plans to provide a notice of current privacy practices regarding protected personal health information (PHI) to enrolled participants. All employers must distribute HIPAA Privacy Notices if the plan is self-funded or if the plan is fully- insured and the employer has access to PHI. If the employer maintains a benefits website, the HIPAA Privacy Notice must be included on the website.

The HIPAA Privacy Notice must be written in plain language and must describe three things: (1) the use and disclosures of PHI that may be made by the group health plan; (2) plan participants' privacy rights; and (3) the group health plan's legal responsibilities with respect to the PHI.

The Department of Health and Human Services (HHS) has developed three different model Privacy Notices for health plans to choose from: booklet version, layered version, and full-page version.

More information can be found at: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-health-information/index.html

Link to OneDigital's privacy policy: https://www.onedigital.com/privacy-policy/

Model Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within the appropriate time period that applies under the plan after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within the appropriate time period that applies under the plan after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the appropriate plan representative.

For additional information on your employer's privacy policy, please contact your HR department.

CONFIDENTIALITY NOTICE

OneDigital Health and Benefits, a division of Digital Insurance, LLC does not sell or share any information we learn about our clients and understands you may have to answer sensitive questions about your medical history, physical condition and personal health habits as required by our insurance carrier partners.

We collect nonpublic personal information from the following sources:

- Information from you, including data provided on applications or other forms, such as name, address, telephone number, date of birth and Social Security number
- Information from your transactions with us and/or our partners such as policy coverage, premium, claim, and payment history.

OneDigital Health and Benefits recognizes the importance of safeguarding the privacy of our clients and prospective clients, and we pledge to protect the confidential nature of your personal information. We understand our ability to provide access to affordable health insurance to businesses and individuals can only succeed with an environment of complete trust.

In the course of business, we may disclose all or part of your customer information without your permission to the following persons or entities for the following reasons:

- To an insurance carrier, agent or credit reporting agency to detect, prevent or prosecute actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a medical care institution or medical professional to verify coverage or benefits, to inform you of a medical problem of which you may or may not be aware or to conduct an audit that would enable us to verify treatment.
- To an insurance regulatory authority, law enforcement or other governmental authority to protect our interests in detecting, preventing or prosecuting actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a third party, for any other disclosures required or permitted by law. We may disclose all of the information that we collect about you, as described above.

Our practices regarding information confidentiality and security: We restrict access to your customer information only to those individuals who need it to provide you with products or services, or to otherwise service your account. In addition, we have security measures in place to protect against the loss, misuse and/or unauthorized alternation of the customer information under our control, including physical, electronic and procedural safeguards that meet or exceed applicable federal and state standards.

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