2022

COBRA Benefits Overview

SAN BERNARDINO MUNICIPAL WATER DEPARTMENT

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Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices on Pages 14-15 for more details.

Open Enrollment

Open Enrollment is your once-a-year opportunity to elect, change or cancel your benefits coverage, or add/drop dependent coverage. As a COBRA participant, you have the opportunity to make changes to your current benefit plans during this Annual Open Enrollment period.

Please consider your options carefully because you may only make changes to your benefit elections during open enrollment, or if you experience a mid-year "qualified status change" (see Page 3). All open enrollment benefit changes will be effective January 1, 2022.

Open Enrollment is October 4 through October 15, 2021

All enrollments must be completed in the Benefit Coordinators Corporation (BCC) system prior to October 15th, 2021 at 3:00pm (PST). Please contact BCC Customer Service at 855-230-0745 Ext. 6414 to make any changes in your enrollment or if you have any questions.

The benefits in this summary are effective:

January 1, 2022 - December 31, 2022

DISCLAIMER

The information in this brochure is a general outline of the benefits offered under the San Bernardino Municipal Water Department benefits program. This brochure may not include all relevant limitations and conditions. Specific details and limitations are provided in the plan documents, which may include a Summary Plan Description (SPD), Evidence of Coverage (EOC), and/or insurance policies. The plan documents contain the relevant plan provisions. If the information in this brochure differs from the plan documents, the plan documents will prevail.

Eligibility and Rules For Benefit Changes

Dependent Eligibility

- Your legal spouse. Proof of marriage certificate and Social Security Number are required.
- Your domestic partner. Must be registered with the California State Registry and at least 18 years of age. Proof of domestic partnership and Social Security Number are required.
- Your or your domestic partner's natural children, stepchildren, adopted children and/or children of which the employee or domestic partner is the legal guardian. Proof of birth certificate and Social Security Number are required. In addition, dependent children must meet the following age requirements:
  - Dependents are eligible up to age 26 for Medical, Dental, and Vision insurance.
- Your physically or mentally handicapped children who meet the plan eligibility guidelines and depend on you for support, regardless of age.
- You must provide proof of dependency (i.e. copy of marriage certificate, birth certificate, domestic partnership registration, etc) within 30 days of enrolling dependents in a plan.

RULES FOR BENEFIT CHANGES DURING THE YEAR

Other than during annual open enrollment, you may only make changes to your benefit elections if you experience a qualified status change or qualify for a "special enrollment". If you qualify for a mid-year benefit change, you may be required to submit proof of the change or evidence of prior coverage.

Qualified Status Changes include:

- **Change in legal marital status**, including marriage, divorce, legal separation, annulment, and death of a spouse
- **Change in number of dependents**, including birth, adoption, placement for adoption, or death of a dependent child
- **Change in employment status that affects benefit eligibility**, including the start or termination of employment by you, your spouse, or your dependent child
- **Change in work schedule**, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits
- **Change in a child's dependent status**, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- **Change in place of residence or worksite**, including a change that affects the accessibility of network providers
- **Change in your health coverage or your spouse's coverage** attributable to your spouse's employment
- **Change in an individual's eligibility for Medicare or Medicaid**
- **A court order** resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child.
- **An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA)** including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan**.**
- **An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act.** Under provisions of the Act, employees have 60 days after the following events to request enrollment:
- Employee or dependent loses eligibility for Medicaid (known as Medi-Cal in CA) or CHIP (known as Healthy Families in CA).
- Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP.

Two rules apply to making changes to your benefits during the year:

- **Any changes you make must be consistent with the change in status, AND**
- **You must make the changes within 30 days of the date the *event* (marriage, birth, etc.) occurs (unless otherwise noted above).**

Please note the following effective dates in regard to Qualifying Events:

- **Adds, terms and changes are effective First of the Following Month of the event.**
- **There are two exceptions**
  - **Birth of a child – added on date of birth**
  - **Death of a Member – term the day after death**

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.

The HMO plan offers comprehensive coverage and a broad network of physicians and hospitals to choose from. Care is coordinated through each member's Primary Care Physician (PCP). Below are the HMO plans available to you.

	Kaiser (PRISM) HMO	Anthem (PRISM) Premier HMO
	In-Network	In-Network
Annual Deductible	None	None
Annual Out-of-Pocket Max	$1,500 per individual $3,000 family limit	$1,500 per individual $3,000 family limit
Lifetime Max	Unlimited	Unlimited
Office Visit		
Primary Provider	$20 copay	$20 copay
Specialist	$20 copay	$20 copay
Preventive Services	Plan pays 100%	Plan pays 100%
Chiropractic Care	$15 copay (up to 20 visits per calendar year)	$20 copay (60 day limit per benefit period for Physical, Occupational and Speech Therapy combined)
Lab and X-ray	Plan pays 100%	Plan pays 100%
Inpatient Hospitalization	Plan pays 100%	Plan pays 100%
Outpatient Surgery	$20 copay	Plan pays 100%
Urgent Care	$20 copay	$20 copay
Emergency Room	$50 copay (copay waived if admitted)	$50 copay (copay waived if admitted)

Prescription Drugs - HMO

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. Here are the prescription drug benefits that are included with our HMO medical plans.

	Kaiser (PRISM) HMO		Anthem (PRISM) Premier HMO
	In-Network		In-Network
Prescription Drug Deductible	None	Prescription Drug Deductible	None
Annual Out-of-Pocket Limit	Combined with Medical	Annual Out-of-Pocket Limit	Combined with Medical
Pharmacy		Pharmacy	
Generic	$10 copay	Tier 1	$10 copay
Preferred Brand	$30 copay	Tier 2[1]	$30 copay
Non-preferred Brand	$30 copay	Tier 3[1]	$45 copay
Supply Limit	30 days	Supply Limit	30 days
Mail Order		Mail Order	
Generic	$20 copay	Tier 1	$20 copay
Preferred Brand	$60 copay	Tier 2[1]	$60 copay
Non-preferred Brand	$60 copay	Tier 3[1]	$90 copay
Supply Limit	100 days	Supply Limit	90 days

[1]If a member requests a brand name or non-formulary drug when a generic drug version exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed charge for the generic drug and the brand name drug.

Medical – PPO

The PPO plan provides choice and flexibility. Participants can choose an in-network provider or go to an out-of-network provider at a higher cost. There are annual deductibles before benefits apply and you are responsible for copays and co-insurance. Service from Non-PPO providers may have lower benefits and be subject to balance billing.

	Anthem (PRISM) Classic PPO	
	In-Network	Out-Of-Network
Annual Deductible	$500 per individual $1,000 family limit	$500 per individual (combined with in-network) $1,000 family limit (combined with in-network)
Annual Out-of-Pocket Max	$2,000 per individual $4,000 family limit	$2,000 per individual (combined with in-network) $4,000 family limit (combined with in-network)
Lifetime Max	Unlimited	Unlimited
Office Visit		
Primary Provider	$20 copay[1]	Plan pays 60% after deductible
Specialist	$20 copay[1]	Plan pays 60% after deductible
Preventive Services	Plan pays 100%	Plan pays 60% after deductible
Chiropractic Care	$20 copay[1] (up to 30 visits per year)	Plan pays 60% after deductible (in-network limitations apply)
Lab and X-ray	Plan pays 90% after deductible	Plan pays 60% after deductible (complex imaging: up to $800 per test; all other: up to $350 per day)
Inpatient Hospitalization	Plan pays 90% after deductible	$250 admission copay then plan pays 60%[2] after deductible (up to $600 per day)
Outpatient Surgery	Plan pays 90% after deductible	Plan pays 60% after deductible (up to $350 per day)
Urgent Care	$20 copay[1]	Plan pays 60% after deductible
Emergency Room	$50 copay then plan pays 90% after deductible (copay waived if admitted)	$50 copay then plan pays 90% after deductible (copay waived if admitted)

[1] Deductible waived

[2] $500 additional deductible for non-Anthem PPO hospital if utilization review not obtained

Prescription Drugs - PPO

Here is the prescription drug benefit that is included with our PPO medical plan.

	Anthem (PRISM) Classic PPO	
	In-Network	Out-Of-Network
Prescription Drug Deductible	None	None
Annual Out-of-Pocket Limit	$5,350 per individual $10,700 per family	Non-Network claims do not apply to the Out-of-Pocket Limit
Pharmacy		
Tier 1	$10 copay	$10 copay
Tier 2[1]	$20 copay	$20 copay
Tier 3[1]	$35 copay	$35 copay
Supply Limit	30 days	30 days
Mail Order		
Tier 1	$15 copay	Not covered
Tier 2[1]	$30 copay	Not covered
Tier 3[1]	$50 copay	Not covered
Supply Limit	90 days	Not applicable

[1]If a member requests a brand name formulary or non-formulary drug when a generic drug exists, the member pays the generic drug copay plus the difference in cost between the prescription drug maximum allowed charge for the generic drug and the brand name drug.

Vision

Routine vision exams can not only correct vision, but also detect more serious health conditions. We offer you a vision plan through EyeMed Vision Care.

	EyeMed Vision Plan	
	In-Network	Out-Of-Network
Examination		
Benefit	$10 copay	Up to $49 Allowance
Frequency	1 x every 12 months from last date of service	In-network limitations apply
Materials	$10 copay	See Schedule Below
Eyeglass Lenses		
Single Vision Lens	$10 copay	Up to $35 Allowance
Bifocal Lens	$10 copay	Up to $49 Allowance
Trifocal Lens	$10 copay	Up to $74 Allowance
Frequency	1 x every 12 months from last date of service	In-network limitations apply
Frames		
Benefit	Up to $130 Allowance + 20% Off Retail Price Over $130	Up to $60 Allowance
Frequency	1 x every 12 months from last date of service	In-network limitations apply
Contacts (Elective) (in lieu of glasses)		
Benefit	Up to $130 Allowance + 15% Off Retail Price Over $130	Up to $104 Allowance
Frequency	1 x every 12 months from last date of service	In-network limitations apply

Note: Benefits are based on a 12 month service year, not a calendar year. This means that you are not eligible for another exam or new lenses or contacts until at least 12 months have passed since you last received services. You are not eligible for new frames until 12 months have passed from the last date of service.

Dental - PPO

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

San Bernardino Municipal Water Department provides you with a comprehensive coverage through Delta Dental of California.

	Delta Dental (PRISM) Dental PPO – Core Plan		Delta Dental (PRISM) Dental PPO – Buy Up Plan	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Calendar Year Deductible	$50 per person	$50 per person	$50 per person	$50 per person
Annual Plan Maximum	$1,000	$1,000	$1,500	$1,500
Diagnostic and Preventive[1]	Plan pays 100%	Plan pays 80%	Plan pays 100%	Plan pays 80%
Basic Services				
Fillings	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Root Canals	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Periodontics	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Major Services	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Orthodontic Services				
Orthodontia	Plan pays 80%	Plan pays 80%	Plan pays 80%	Plan pays 80%
Lifetime Maximum	$2,000 lifetime per person	$2,000 lifetime per person	$2,000 lifetime per person	$2,000 lifetime per person
Children to age 18	Covered	Covered	Covered	Covered
Adults	Covered	Covered	Covered	Covered

[1] Deductible is waived for Diagnostic & Preventive (D&P) and Orthodontics.

Dental - HMO

Here is an overview of our third dental plan, a HMO plan offered through Delta Dental of California. This plan works like the medical HMO and care is coordinated through an assigned primary care provider. The plan offers the convenience of scheduled copays for specific procedures with no deductible or annual maximum.

	DeltaCare HMO (PRISM)
	In-Network only
Calendar Year Deductible	None
Annual Plan Maximum	Unlimited
Diagnostic and Preventive	$0 - $45 copay (refer to Patient Charge Schedule for applicable copay)
Basic Services	
Fillings	$0 - $110 copay (refer to Patient Charge Schedule for applicable copay)
Root Canals	$0 - $280 copay (refer to Patient Charge Schedule for applicable copay)
Periodontics	$0 - $280 copay (refer to Patient Charge Schedule for applicable copay)
Major Services	$25 - $240 copay (refer to Patient Charge Schedule for applicable copay)
Orthodontic Services	
Orthodontia	$1,700 – child to age 19 $1,900 - adult
Lifetime Maximum	Unlimited
Adult & Dependent Children	Covered

Cost of Coverage

Anthem Premier HMO - Medical	Cost
Employee Only	$635.50
Employee + Spouse	$1,263.50
Employee + Family	$1,695.50
Anthem Classic PPO - Medical	**Cost**
Employee Only	$889.50
Employee + Spouse	$1,767.50
Employee + Family	$2,373.50
Kaiser Permanente HMO - Medical	**Cost**
Employee Only	$566.50
Employee + Spouse	$1,126.50
Employee + Family	$1,510.50

Delta Dental HMO - Dental	Cost
Employee Only	$16.80
Employee + Spouse	$29.90
Employee + Family	$43.80
Delta Dental PPO Core Plan - Dental	**Cost**
Employee Only	$35.10
Employee + Spouse	$75.80
Employee + Family	$103.50
Delta Dental PPO Buy Up Plan - Dental	**Cost**
Employee Only	$40.80
Employee + Spouse	$88.40
Employee + Family	$120.80
EyeMed Vision PPO - Vision	**Cost**
Employee Only	$6.13
Employee + Spouse	$11.58
Employee + Family	$16.96

PLEASE NOTE THE ABOVE OPTION COSTS DO NOT CONTAIN THE 2% COBRA ADMINISTRATION FEE.

Important Plan Notices and Documents

NOTICE OF AVAILABILITY OF HIPAA PRIVACY NOTICE

The federal Health Insurance Portability and Accountability Act (HIPAA) requires that we periodically remind you of your right to receive a copy of the Insurance Carriers' HIPAA Privacy Notices. You can request copies of the Privacy Notices by contacting the Human Resources Department or by contacting the insurance carriers directly.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act (WHCRA) requires employer groups to notify participants and beneficiaries of the group health plan, of their rights to mastectomy benefits under the plan. Participants and beneficiaries have rights for coverage to be provided in a manner determined in consultation with the attending Physician 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 are subject to the same deductible and co-payments applicable to other medical and surgical procedures provided under this plan. You can contact your health plan's Member Services for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

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 FOR MEDICAL/HEALTH PLAN COVERAGE

If you decline enrollment in Public Risk Innovation, Solutions, and Management's (PRISM) 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 Public Risk Innovation, Solutions, and Management's (PRISM) 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 30 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 [medical plan OR health plan] enrollment within [30/31] 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 30 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 the qualifying event. In addition, you may enroll in Public Risk Innovation, Solutions, and Management's (PRISM) medical plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.
Note: If your dependent becomes eligible for special enrollment rights, you may add the dependent to your current coverage or change to another health plan.

NOTICE OF CHOICE OF PROVIDERS

Public Risk Innovation, Solutions, and Management (PRISM) generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your plan administrator.
For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from Public Risk Innovation, Solutions, and Management (PRISM) or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology.
The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your plan administrator.

ACA 1557 Notice

Nondiscrimination statement for significant publications and signification communications:
Public Risk Innovation, Solutions, and Management complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

MEDICARE PART D NOTICE

Important Notice from Public Risk Innovation, Solutions, and Management (PRISM) 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 Public Risk Innovation, Solutions, and Management's (PRISM) 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. Your plan has determined that the prescription drug coverage offered by PRISM 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 Public Risk Innovation, Solutions, and Management (PRISM) coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Public Risk Innovation, Solutions, and Management (PRISM) is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Public Risk Innovation, Solutions, and Management (PRISM) prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Public Risk Innovation, Solutions, and Management (PRISM) 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 Your Options under Medicare 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 Public Risk Innovation, Solutions, and Management (PRISM) changes. You also may request a copy of this notice at any time.

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, 2022
Name of Entity/Sender:	San Bernardino Municipal Water Department
Contact-Position/Office:	Human Resources
Address:	1350 S. E Street, Building B, San Bernardino, CA 92408
Phone Number:	(909) 453-6091

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. 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: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx	Phone: 1-800-541-5555
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	
FLORIDA – Medicaid	
Website: http://flmedicaidtplrecovery.com/hipp/	Phone: 1-877-357-3268
GEORGIA – Medicaid	
Website: Medicaid 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/ All other Medicaid Website: http://www.indianamedicaid.com	 Phone: 1-877-438-4479 Phone 1-800-403-0864

IOWA – Medicaid	
Medicaid Website: https://dhs.iowa.gov/ime/members Hawki Website: http://dhs.iowa.gov/hawki	Medicaid Phone: 1-800-338-8366 Phone: 1-800-257-8563
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/default.htm	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 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Kentucky Medicaid Website: https://chfs.ky.gov/	 Phone: 1-855-459-6328 Phone: 1-877-524-4718
LOUISIANA – Medicaid	
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6027 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	
MASSACHUSETTS – Medicaid and CHIP	
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ 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/medical-assistance.jsp Phone: 1-800-657-3739	
MISSOURI – Medicaid	
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	
MONTANA – Medicaid	
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	
NEBRASKA – Medicaid	
Website: http://www.ACCESSNebraska.ne.gov Lincoln: (402) 473-7000	Phone: (855) 632-7633 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 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Phone: 603-271-5218
NEW JERSEY – Medicaid and CHIP	
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	
NEW YORK – Medicaid	
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	
NORTH CAROLINA – Medicaid	
Website: https://dma.ncdhhs.gov/	Phone: 919-855-4100
NORTH DAKOTA – Medicaid	
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	
OKLAHOMA – Medicaid and CHIP	
Website: http://www.insureoklahoma.org	Phone: 1-888-365-3742
OREGON – Medicaid and CHIP	
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
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 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
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm Phone: 1-855-242-8282
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, 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

Paperwork Reduction Act Statement

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

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

Plan Contacts

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

Plan Type	Provider	Phone Number	Website	Policy/Group #
Medical	Kaiser HMO	800-464-4000	www.kp.org	232111
Medical	Anthem Premier HMO	800-967-3015	www.anthem.com/ca/prism	175075
Medical	Anthem Classic PPO	800-967-3015	www.anthem.com/ca/prism	175075
Medical	Express Scripts (PPO only)	877-554-3091	www.express-scripts.com	175075Q003
Dental	Delta Dental PPO	888-335-8227	www.deltadentalins.com	17497
Dental	DeltaCare HMO	800-422-4234	www.deltadentalins.com	19749
Vision	EyeMed	866-723-0513	www.eyemedvisioncare.com	9928466
COBRA Administration	Benefits Coordinators Corporation	855-230-0745 Ext. 6414	https://benxcel.net	N/A
Enrollment & Call Center for COBRA Participants	Benefits Coordinators Corporation	855-230-0745 Ext. 6414	https://benxcel.net	N/A
San Bernardino Municipal Water Department	Human Resources	909-453-6091	www.sbmwd.org	N/A
Deferred Compensation Section 457 Plan	Empower	800-743-5274	www.retiresmart.com	63122