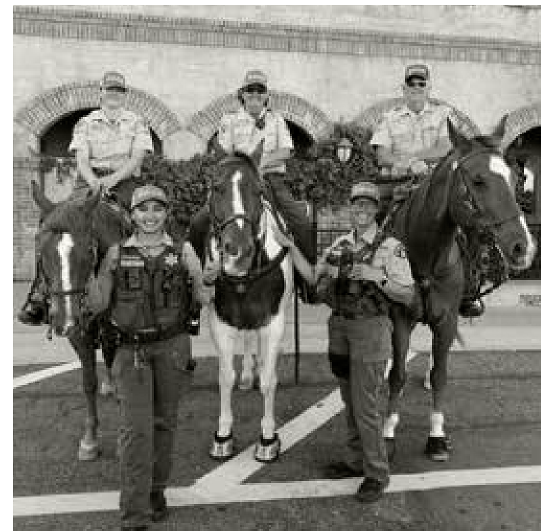
RIVERSIDE SHERIFFS' ASSOCIATION BENEFIT TRUST

2024 RETIREE GUIDE



RIVERSIDE SHERIFFS' ASSOCIATION BENEFIT TRUST OPEN ENROLLMENT 2024

Important Open Enrollment Information

Please Read Carefully

OPEN ENROLLMENT

Open Enrollment will run from **October 1st through October 31st**. You can log into Plansource to make your changes 24 hours a day, 7 days a week from your own computer or mobile device. Laptops will be available in the RSA benefits office **from 8:00 am – 5:00 pm Monday through Thursday**, except for Monday, October 9th in observance of Columbus Day. **All changes will take effect January 1, 2024**.

The Trustees of the RSA Benefit Trust work very hard alongside our consultants to ensure that the Benefit Trust offers best-in-class healthcare plans for retirees at the lowest possible costs. For 2024, the Kaiser medical trends are increasing significantly across the board. The average Kaiser increase for Southern California based groups is over 14%! Because of this significant increase in trend, the RSA non-Medicare Kaiser premiums are increasing 11.5% in 2024. This comes after three straight years of the Kaiser plan receiving premium decreases resulting in a five-year average premium increase of 2.8%. The Anthem medical plan premiums will not be increasing in 2024. There will also be no copay changes to any of the medical plans in 2024. Medical premiums can be found beginning on page 7.

There will be a 5% increase to the UHC Union DHMO premiums. All other dental and vision plan premiums will remain the same in 2024!

OUR VISION PLAN IS CHANGING

VSP will be the new vision carrier beginning January 1st, 2024! The rates will stay the same, however the benefits are significantly better (see examples below). VSP was also chosen because they have the largest national network of PPO providers with over 4,000 more doctors than MES! However, not all providers will remain in-network with VSP. You can find additional VSP information throughout this booklet (important provider info on page 5).

- Frames and Contact Lens Allowance: Increasing to $200 (Currently $150)
- Contact Lens Fitting Copay: Decreasing to $50 (Currently $75) and now includes Premium Fittings
- Polycarbonate Lenses In-Network: Covered in full with a $10 copay (Currently only $85 allowance)
- Lightcare and **eyeconic.com** are included! More information included in this booklet.

Please log into the PlanSource System and verify all the insurance plans that you have are correct, as well as read any changes those plans may have for 2024 (login instructions can be found on page 24). The RSA Benefit Trust staff will be available to assist you in verifying your current plans so you can determine if you wish to make any changes.

IF YOU DO NOT WISH TO MAKE A CHANGE TO YOUR CURRENT BENEFITS THEN NO ACTION IS REQUIRED DURING OPEN ENROLLMENT.

For Your Board of Trustees,

Randall Wortman

Benefit Trust Chairman

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2024 OPEN ENROLLMENT

OCTOBER 1, 2023 – OCTOBER 31, 2023

Log in at **benefits.plansource.com** to make changes (see page 24 for instructions). If you are not making changes, nothing needs to be done but it may be a good time to update your information and/or beneficiaries!

BENEFIT PLAN ELIGIBILITY

To be eligible to participate in the Trust's programs as a retiree, a participant, who is no longer an active full-time employee, must have retired from the County of Riverside, must be receiving retirement benefits, must have retired from a job class in a bargaining unit represented by or affiliated with the Riverside Sheriffs Association and must maintain continuous membership with the Riverside Sheriffs' Association at all times.

ELIGIBLE DEPENDENTS:

- Your legal spouse or qualified domestic partner
- Children under the age of 26, regardless of student, dependency, or marital status
- Children who are past the age of 26 and are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return

CHANGING BENEFITS AFTER ENROLLMENT

During the year, you cannot make changes to your benefits unless you have a Qualified Life Event. If you do not make changes to your benefits within 30 days of the Qualified Life Event, you will have to wait until the next annual Open Enrollment period to make changes (unless you experience another Qualified Life Event).

QUALIFIED LIFE EVENT		DOCUMENTATION NEEDED
Change in Marital Status	Marriage	Copy of marriage certificate
	Divorce/Legal Separation	Copy of divorce decree
	Death	Copy of death certificate
Change in Number of Dependents	Birth or adoption	Copy of birth certificate or copy of legal adoption papers
	Stepchild	Copy of birth certificate plus a copy of the marriage certificate between member and spouse
	Death	Copy of death certificate
Change in Spouse/DP Group Benefits	Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage
Change in Address	Moving out of state	Updated address

DOMESTIC PARTNERSHIP

A Domestic Partner of an eligible member shall satisfy the Trust's general eligibility so long as both the members of the partnership meet the following criteria:

- Provide a copy of a valid Declaration of Domestic Partnership filed with the Secretary of State pursuant to Section 297 of the Family Code
- Submit a signed Affidavit of Partnership for Insurance Carriers
- Are at least 18 years of age
- Share a common residence
- Are unmarried and not a member of another domestic partnership
- Are not related by blood that would prevent you from being married in the state of California

Contact the benefits office for a list of required documents showing proof of Domestic Partnership.

PLAN CHANGES

EFFECTIVE JANUARY 1, 2024

VSP Vision	In-network Retailers: Costco, Walmart, Sam's Club, VisionWorks Out-of-network Retailers: Sears, Target, LensCrafters, America's Best
All Anthem Medical Plans	Identity Protection Services information has been relocated from the EOC to: **www.allclearid.com/anthem**
All Anthem Medical Plans	988 Suicide and Crisis Lifeline benefit coverage language has been added to your contracts.
All Anthem Medical Plans	Anthem has clarified that Virtual Care benefits listed in the contracts and summaries apply to Virtual-Care Only providers through Anthem's mobile site or app.
All Anthem Medical Plans	Anthem has clarified that many benefits listed in the benefit summaries are based on the setting in which covered services are provided. For example, Allergy Services in a doctor's office setting v. pharmacy or Behavioral Health services in a doctor's office setting or hospital may be covered differently.
All Anthem Medical Plans	If a Contraceptive Drug doesn't have a generic drug available and the provider determines it medically necessary, the member may obtain coverage of the brand name drug with no cost sharing IF THE PROVIDER SUBMITS AN EXCEPTION REQUEST.

MEDICAL

Medical insurance is essential to your well-being, and our Medical coverage provides you and your family the protection you need for everyday health issues or when the unexpected happens.

PARTS OF YOUR MEDICAL PLAN

- **Preventive care** – Always 100% covered when you use in-network providers and includes things like physical exams, flu shots and screenings.
- **Annual deductible amounts** – The amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay.
- **Annual out-of-pocket maximums** – The most you will pay each year for eligible in-network and out-of-network services, including prescriptions. After you reach your out-of-pocket maximum, the plan picks up the full cost of covered medical care for the remainder of the year.
- **Copays** – A copay is a fixed amount you pay for a health care service. Copays do not count toward your deductible but do count toward your annual out-of-pocket maximum.
- **Coinsurance** – Once you've met your deductible, you and the plan share the cost of care, called coinsurance.

HOW MEDICARE WORKS

ELIGIBILITY

Generally, you are eligible for Medicare if you are age 65 or older, or if you receive Medicare disability benefits, regardless of your age.

- If you retire when you are age 65 or older, you are immediately eligible for Medicare.
- If you retire before age 65, you become eligible for Medicare at age 65.
- Once you are eligible for Medicare, it becomes your primary medical coverage. Any additional coverage you have will "supplement" what Medicare doesn't cover.
- Medicare eligibility is determined on an individual basis. For example, your spouse may be Medicare-eligible, while you remain non-eligible — or vice versa.
- Unless you have a Medicare disability, you are non-Medicare eligible while you are under age 65, even if you retire earlier than that age.

WHAT DOES MEDICARE COVER?

- Medicare Part A – Helps pay for inpatient care in a hospital or skilled nursing facility (following a hospital stay) and some home health care and hospice care.
- Medicare Part B – Helps pay for doctors' services and other medical services and supplies not covered by Medicare Part A. Premiums apply.
- Medicare Part D – Helps pay for prescription drugs doctors prescribe for treatment. Part D is not considered part of "basic" Medicare coverage. Premiums apply.

Rates do not reflect RAP or county contribution (if applicable)

NON-MEDICARE HMO PLAN

	HMO	HMO (CAL CARE)	SELECT HMO	EPO (BLYTHE ONLY)
	MONTHLY PREMIUM RATE			
Member Only	$854	$1,095	$906	$1,095
Member + Spouse	$1,416	$1,646	$1,358	$1,646
Member + Child(ren)	$1,375	$1,596	$1,317	$1,596
Member + Family	$1,773	$2,046	$1,690	$2,046
	PLAN DETAILS*			
Network	Full Network	Full Network	**Limited** Network	PPO
Deductible	None	None	None	None
Primary Care Office Visit	$5 Copay	$5 Copay	$5 Copay	$5 Copay
Specialist Office Visit	$5 Copay	$5 Copay	**$40**/Visit	$5 Copay
Virtual Doctor Visit	No Charge	$5 Copay	$5 Copay	$5 Copay
Allergy Testing	No Charge	$5 Copay	$5 Copay	No Charge
Preventive Care (All Ages)	No Charge	No Charge	No Charge	No Charge
Diagnostic Lab (Most*)	No Charge	No Charge	No Charge	No Charge
Vision / Hearing Screenings	No Charge	No Charge	No Charge	No Charge
Durable Medical Equipment	No Charge	No Charge	**50% Coinsurance**	No Charge
Urgent Care Visits	$5 Copay	$5 Copay	$5 Copay	$5 Copay
Hospital Services	No Charge	No Charge	**$250**/Admit	No Charge
Outpatient Surgery	$5 Per Procedure	No Charge	**$125**/Visit	No Charge
Emergency Room	$50; Waived if Admitted	$50; Waived if Admitted	$150; Waived if Admitted	$50; Waived if Admitted
Ambulance	No Charge if Medically Necessary	No Charge if Medically Necessary	$100 Copay per Trip	No Charge if Medically Necessary
Annual Out-of-Pocket Maximum	$1,500 Person/ $3,000 Family	$1,000/Family Member (up to 3)	$2,000 Person/ $4,000 Family	No Out-of-Pocket Limit
Prescription Drugs Generic/Brand Name/ Non-Formulary	Copay: $0/$10 (30-Day Supply) $0/$20 (31- to 100-Day Supply)	Copay: $0/$10/$40 (30-Day Supply)	**$250/$500** Cal Year Deductible; Waived for Generics **$0/$35/$50** 30-Day Supply	Copay: $0/$10/$40 (30-Day Supply)
Manipulation Therapy (Chiropractic, etc.)	N/A See Benefit Listed Below	$5/ (Combined with Physical Therapy) Limited to a 60-day Period of Care After an Illness or Injury	**$20**/(Combined with Physical Therapy) Limited to a 60-day Period of Care After an Illness or Injury	No charge; Limit 30 Visits per Cal Year Combined Physical & Occupational Therapy
Chiropractic Rider- All Plans	$5/20 visits per calendar year/Must use ASH Providers	$5/20 visits per calendar year/Must use ASH Providers	$5/20 visits per calendar year/Must use ASH Providers	N/A

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Rates do not reflect RAP or county contribution (if applicable)

NON-MEDICARE PPO PLAN

RETIREE NON-MEDICARE MEDICAL	PPO	
	MONTHLY PREMIUM RATE	
Member Only	$814	
Member + Spouse	$1,544	
Member + Child(ren)	$1,510	
Member + Family	$2,031	
	PLAN DETAILS*	
Network	PPO	Non-PPO (Out of Network)
Deductible	$250 Person/$750 Family	$250 Person /$750 Family
Primary Care Office Visit	$20 Copay	40% Coinsurance
Specialist Office Visit	$20 Copay	40% Coinsurance
Virtual Doctor Visit	$20 Copay	40% Coinsurance
Allergy Testing	20% Coinsurance	40% Coinsurance
Preventive Care (All Ages)	No Charge	40% Coinsurance
Diagnostic Lab (Most*)	20% Coinsurance	40% Coinsurance
Vision / Hearing Screenings	No Charge	Reimbursed up to $42
Durable Medical Equipment	20% Coinsurance	40% Coinsurance
Urgent Care Visits	$20 Copay	40% Coinsurance
Outpatient Surgery	20% Coinsurance	40% Coinsurance
Hospital Services	20% Coinsurance	$500 Copay and 40% Coinsurance
Emergency Room	$25 Copay; Waived if Admitted	
Ambulance	20% Coinsurance	
Annual Out-of-Pocket Maximum	$2,000 Person/$4,000 Family PPO and Out-of-Network Providers Combined	
Prescription Drugs Generic/Brand Name/ Non-Formulary	Copay: $5/$10/$40 30-Day Supply	50% Coinsurance up to $250/Script
Manipulation Therapy (Chiropractic, etc.)	$5 Copay 20 Visits per Year	

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NON-MEDICARE OUT-OF-STATE PPO PLAN

	PPO	
	MONTHLY PREMIUM RATE	
Retiree Only	$814	
Retiree + Spouse	$1,544	
Retiree + Child(ren)	$1,510	
Retiree + Family	$2,031	
	PLAN DETAILS*	
Network	PPO	Non-PPO (Out of Network)
Deductible	$250 Person/$750 Family	$250 Person/$750 Family
Primary Care Office Visit	$10 Copay	40% Coinsurance
Specialist Office Visit	$10 Copay	40% Coinsurance
Virtual Doctor Visit	$10 Copay	40% Coinsurance
Allergy Testing	20% Coinsurance	40% Coinsurance
Preventive Care (All Ages)	No charge	40% Coinsurance
Diagnostic Lab (Most*)	20% Coinsurance	40% Coinsurance
Vision / Hearing Screenings	No charge	Reimbursed up to $42
Durable Medical Equipment	20% Coinsurance	40% Coinsurance
Urgent Care Visits	$10 Copay	40% Coinsurance
Outpatient Surgery	20% Coinsurance	40% Coinsurance
Hospital Services	20% Coinsurance	$500 Copay and 40% Coinsurance
Emergency Room	$100 Copay and 20% Coinsurance; Copay Waived if Admitted	
Ambulance	20% Coinsurance	
Annual Out-of-Pocket Maximum	$2,000 Person/$4,000 Family	$6,000 Person/$12,000 Family
Prescription Drugs Generic/Brand Name/ Non-Formulary	Copay: $5/ $10/ $40 30 day supply	50% Coinsurance up to $250/Script
Manipulation Therapy (Chiropractic, etc.)	$10 Copay; 30 Visits per Cal Year PPO/Non-PPO Combined	40% Coins; 30 Visits per Cal Year PPO/Non-PPO Combined

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Rates do not reflect RAP or county contribution (if applicable)

MEDICARE PARTS A AND B | HMO PLAN OPTIONS

	KAISER SENIOR ADVANTAGE	Anthem. ANTHEM SELECT HMO CALIFORNIACARE	Anthem. ANTHEM HMO CALIFORNIACARE	Anthem. ANTHEM EPO PLAN (BLYTHE ONLY)
	MONTHLY RATES			
Retiree with Medicare	$242	$450	$458	$458
Retiree & Spouse with Medicare	$462	$879	$899	$899
Retiree &Spouse w/out Medicare	$804	$885	$978	$978
Retiree w/out Spouse with Medicare	$1,074	$1,336	$1,533	$1,533
Retiree w/ Child w/out Medicare	$763	$885	$978	$978
Retiree w/ Children w/out Medicare	$763	$1,202	$1,368	$1,368
Retiree & Spouse with Child w/out Medicare	$819	$1,314	$1,419	$1,419
Retiree & Spouse with Children w/out Medicare	$819	$1,631	$1,809	$1,809
Retiree with Spouse & Child(ren) w/out Medicare	$1,161	$1,202	$1,368	$1,368
Retiree & Child(ren) w/out Spouse with Medicare	$1,431	$1,747	$2,034	$2,034
DEDUCTIBLE	**NONE**	**NONE**	**NONE**	**NONE**
PHYSICIAN SERVICES				
Office Visits	$10 per visit	$5/visit - primary care dr.	$5 per visit	$5 per visit
Online Office Visits (livehealthonline.com)	Not Covered	$5/visit	$5 per visit	$5 per visit
Allergy testing	$10 per procedure	$5/visit - primary care dr.	$5 per visit	$5 per visit
Allergy injection visits	No charge	$5/visit - primary care dr.	$5 per visit	$5 per visit
Well baby & child care	No charge	No charge	No charge	No charge
Immunizations	No charge	No charge	No charge	No charge
Vision & Hearing Screening	Screening No charge, $10 refraction, $10 hearing exam	No charge	No charge	No charge
Diagnostic lab & X-ray in physician office	No charge	No charge, advanced imaging not included	No charge	No charge
Specialist Consultation	$10 per visit	$40 per visit	$5 per visit	$5 per visit

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MEDICARE PARTS A AND B | HMO PLAN OPTIONS (CONT.)

	KAISER SENIOR ADVANTAGE	ANTHEM SELECT HMO CALIFORNIACARE	ANTHEM HMO CALIFORNIACARE	ANTHEM EPO PLAN (BLYTHE ONLY)
INPATIENT HOSPITAL SERVICES				
Preauthorized semi-private room	No charge	$250/admit	No charge	No charge
Intensive/coronary care unit	No charge		No charge	No charge
Operating room and anesthesia	No charge		No charge	No charge
X-ray, laboratory testing – diagnostic studies	No charge		No charge	No charge
MENTAL HEALTH				
Outpatient	$10/individual $5/group	$5 per visit	$5 per visit	$5 per visit
Inpatient; as medically necessary	No charge Pre-authorization Required	$250/admit Pre-authorization Required	$0 copay Pre-authorization Required	$0 copay Pre-authorization Required
SUBSTANCE ABUSE; ALCOHOL & CHEMICAL DEP.				
Outpatient	$10/individual $5.00/group	$5 per visit	$5 per visit	$5 per visit
Inpatient; as medically necessary	No charge Pre-authorization Required	$250/admit Pre-authorization Required	$0 copay Pre-authorization Required	$0 copay Pre-authorization Required
Emergency Room	$50; waived if admitted	$150; waived if admitted	$50; waived if admitted	$50; waived if admitted
Ambulance	No charge-as medically necessary	$100/trip	No charge-as medically necessary	No charge-as medically necessary
Durable Medical Equipment	No charge in accordance with formulary	50% – Hearing aids excluded	No charge/Limit of 1 hearing aid per ear every three yrs	No charge/Limit of 1 hearing aid per ear every three yrs
Home Health Care Benefit	No charge 100 visits per cal yr	$5/visit 100 visits per cal yr	$5/visit 100 visits per cal yr	No charge, limited to 100 visits per cal yr
Prosthetic Devices	No charge	No charge	No charge	$0 copay
Annual Out of Pocket Maximum Ind/Fam	$1,500/$3,000	$2,000/$4,000	$1,000/$2,000/$3,000	Not applicable
PART D PRESCRIPTION DRUGS				
Generic/Brand Name/ Non-formulary	$5/$10 30-day supply $10/$20 31-60-day supply $15/$30 61-100-day supply	$250/Cal yr deductible (waived for generic) $10/$35/$50 30-day supply	$5/$10/$40 30-day supply	$5/$10/$40 30-day supply
Mail Order Pharmacy	$5/$10 30-day supply $10/$20 31-60-day supply	$250/Cal yr deductible (waived for generic) $10/$70/$100 - 90 day	$10/$20/$80 90-day supply	$10/$20/$80 90-day supply
Chiropractic	N/A See benefit listed below	$5/ (combined with physical therapy) Limited to a 60-day period of care after an illness or injury	$5/Visits / (combined with physical therapy) Limited to a 60-day period of care after an illness or injury	No charge, 30 visits per cal yr - comb. physical & occupational therapy
Chiropractic Rider	$5/ 20 visits per year Must use ASH providers	$5/ 20 visits per calendar year Must use ASH providers	$5 / 20 visits per calendar year Must use ASH providers	None

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Rates do not reflect RAP or county contribution (if applicable)

MEDICARE PARTS A AND B | PPO PLAN

	PPO	
	MONTHLY RATES	
Retiree with Medicare	$526	
Retiree & Spouse with Medicare	$1,016	
Retiree & Spouse w/out Medicare	$1,258	
Retiree w/out Spouse with Medicare	$1,317	
Retiree & Child w/out Medicare	$1,258	
Retiree & Children w/out Medicare	$1,743	
Retiree & Spouse with Child w/out Medicare	$1,748	
Retiree & Spouse with Children w/out Medicare	$2,233	
Retiree with Spouse & Child(ren) w/out Medicare	$1,743	
Retiree & Child(ren) w/out Spouse with Medicare	$2,013	
DEDUCTIBLE	**$250/INDIVIDUAL I $750/FAMILY AGGREGATE MAX**	**$250/INDIVIDUAL I $750/FAMILY AGGREGATE MAX**
PHYSICIAN SERVICES	**PPO**	**OPT-OUT**
Office Visits	$20 per visit, ded waived	40%
Online Office Visits (livehealthonline.com)	N/A	N/A
Allergy testing & injections	20%	40%
Well baby & child care	No Copay	Not covered
Immunizations	No Copay	Not covered
Vision & Hearing Screening	No Copay	Not covered
Diagnostic lab & x-ray in physician office	20%	40%
Specialist Consultation	$20 per visit	40%
INPATIENT HOSPITAL SERVICES		
Preauthorized Semi-Private room	20%	40%
Intensive/coronary care unit	20%	40%
Operating room and anesthesia	20%	40%
X-ray, laboratory testing –diagnostic studies	20%	40%

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MEDICARE PARTS A AND B | PPO PLAN (CONT.)

	PPO	
MENTAL HEALTH		
Outpatient	$10/visit	40% visit
Inpatient	No charge Pre-authorization Required	40% Pre-authorization Required
SUBSTANCE ABUSE; ALCOHOL & CHEMICAL DEP.		
Outpatient	$10/visit	40% visit
Inpatient	No charge Pre-authorization Required	40% Pre-authorization Required
Emergency Room	$25; waived if admitted	$25; waived if admitted
Ambulance	20%	20%
Durable Medical Equipment	20%; limit of 1 hearing aid per ear every three years	40%; limit of 1 hearing aid per ear every three years
Prosthetic Devices	20%	40%
Annual Out of Pocket Maximum Ind/Fam	$2 ,000 Individual/ $4,000 Family PPO & Opt-Out Providers Combined	
Lifetime Maximum	Unlimited	
PART D PRESCRIPTION DRUGS		
Generic/Brand Name/Non-formulary	$5 / $10 / $40, 30 day supply	$5 / $10 / $40, 30 day supply
Mail Order Pharmacy	$10 / $20 / $80, 90 day supply	$10 / $20 / $80, 90 day supply
Chiropractic	$5 Per Visit 20 Visit Per Calendar Year	

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Rates do not reflect RAP or county contribution (if applicable)

MEDICARE PARTS A AND B | OUT-OF-STATE PPO PLAN

OUT-OF-STATE MEDICARE PARTS A AND B	INSURED PERSONS ARE RESPONSIBLE FOR ANY DIFFERENCE BETWEEN THE ALLOWED AMOUNT & ACTUAL CHARGES, AS WELL AS ANY DEDUCTIBLE & PERCENTAGE CO-PAYMENT.
	MONTHLY RATES
Retiree with Medicare	$713
Retiree & Spouse with Medicare	$1,397
Retiree & Spouse w/out Medicare	$1,445
Retiree w/out Spouse with Medicare	$1,478
Retiree & Child w/out Medicare	$1,445
Retiree & Children w/out Medicare	$1,930
Retiree & Spouse with Child w/out Medicare	$2,129
Retiree & Spouse with Children w/out Medicare	$2,614
Retiree with Spouse & Child(ren) w/out Medicare	$1,930
Retiree & Child(ren) w/out Spouse with Medicare	$2,174
DEDUCTIBLE	$250/INDIVIDUAL I $750/FAMILY AGGREGATE MAX
PHYSICIAN SERVICES	
Office Visits	$10 per visit
Online Office Visits (livehealthonline.com)	$10 per visit
Well baby & child care (birth through age 6)	No Copay
Immunizations (birth through age 6)	No Copay
Preventive Care (persons age 7 and older)	No Copay
Diagnostic lab & x-ray	20%
Specialist Consultation	$10 per visit
Radiation Therapy, Chemotherapy, and Hemodialysis treatment	20%
INPATIENT HOSPITAL SERVICES	
Physician visits	20%, includes skilled nursing facility visits
Surgeon & surgical assistant; anesthesiologist or anesthetist	20%
Preauthorized Semi-Private room	20%
Intensive/coronary care unit	20%
Operating room and anesthesia	20%
X-ray, laboratory testing –diagnostic studies	20%

*The above is a brief summary of benefits only and not an offer of insurance. Please refer to your Evidence of Coverage for a complete description of benefits and exclusions.

MEDICARE PARTS A AND B | OUT-OF-STATE PPO PLAN (CONT.)

	INSURED PERSONS ARE RESPONSIBLE FOR ANY DIFFERENCE BETWEEN THE ALLOWED AMOUNT & ACTUAL CHARGES, AS WELL AS ANY DEDUCTIBLE & PERCENTAGE CO-PAYMENT.
MENTAL HEALTH	
Inpatient	20%, preauthorization required, waived for emergency admissions
Outpatient physician visits	$10 per visit
SUBSTANCE ABUSE; ALCOHOL & CHEMICAL DEP.	
Inpatient	20%, preauthorization required, waived for emergency admissions
Outpatient physician visits	$10 per visit
Emergency Room	20% - $50 deductible per visit (waived if admitted)
Ambulance	20%
Durable Medical Equipment	20% - Hearing aid provision will now be separated from the Durable Medical Equipment Benefit, limited to 1 hearing aid per ear every three years
Prosthetic Devices	20%
Lifetime Maximum	Unlimited
PART D PRESCRIPTION DRUGS	
Generic/Brand Name/Non-formulary	$5 / $10 / $40, 30 day supply
Mail Order Pharmacy	$10 / $20 / $80, 90 day supply
Physical Therapy, Physical Medicine, Occupational Therapy & Chiropractic	20% Chiropractic - limited to 30 visits per year

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PHARMACY

When you enroll in Medical coverage, you will also receive prescription benefits. Be sure to check the formulary for a full list of the prescriptions that are covered by the plan. Remember, you can always ask your doctor about lower-cost alternatives. Generic drugs tend to be less expensive than brand-name drugs, so keep that in mind when shopping around.

SAVE ON PRESCRIPTION DRUGS

ASK FOR GENERICS

Generic and brand-name drugs have the same active ingredients, which means they have the same efficacy for treating your condition. The main difference is the cost to you.

Brand-name drugs tend to be more expensive because of the lengthy drug development process. Manufacturers charge more to recoup costs. When a patent expires, other manufacturers can produce the medication, and competition drives the price down.

HOME DELIVERY

Enjoy the convenience and savings of home delivery for medications you take on a regular basis through our mail-order prescription program. The larger 90-day supply is mailed directly to your home — saving you time and money.

DENTAL

Taking care of your oral health is not a luxury; it is a necessity to long-term optimal health. With a focus on prevention, early diagnosis and treatment, Dental insurance can greatly reduce your costs when it comes to restorative and emergency procedures. Preventive services are covered at no cost to you and include routine exams and cleanings. You will pay only a small deductible and coinsurance for basic and major services.

When you visit a dentist in the network, you will maximize your savings. These dentists have agreed to reduced fees, which means you won't get charged more than your expected share of the bill.

	DMO D125H	DMO UNION D1065	HMOCA11A	PPO PLAN	
Member Only	$18.00	$29.40	$19.00	$49.00	
Member + One Dependent	$32.00	$48.18	$34.00	$85.26	
Member + 2 or More Dependents	$49.00	$71.14	$49.00	$140.14	
Network	CA Select DHMO	CA Select Direct Compensation	DeltaCare®	In-Network	Out-of-Network*
Annual Maximum	None	None	None	$1,000/Cal Yr. $2,000 Ortho Lifetime	$1,000/Cal Yr. $2,000 Ortho Lifetime
Diagnostic and Preventive Exempt From Maximum				Yes	Yes
Deductible	None	None	None	None	$50, waived for preventive services
PREVENTIVE SERVICES					
Office Visit/ Oral Exams	No Charge	No Charge	No Charge	No Charge	No Charge
Complete X-rays	No Charge	No Charge	No Charge	No Charge	No Charge
Prophylaxis (Cleaning)	No Charge 1 per 6 month	No Charge 1 per 6 month	No Charge 1 per 6 month	No Charge 2 Per Calendar Year	
Topical Fluoride Treatments	No Charge	No Charge	No Charge	No Charge	No Charge
RESTORATIVE SERVICES					
Amalgam – 1, 2, or 3 tooth surface	No Charge	No Charge	No Charge	20%	50%
CROWN, CAST AND PROSTHETICS**					
Crown 3/4 Cast Metal	$125	No Charge	$210	40%	50%
Resin Crown (Not for Molars)	$125	No Charge	$95-$195	40%	50%
Porcelain/ Ceramic (Not for Molars)	$215	No Charge	$240	40%	50%
Pontic Cast Noble Metal	$125	No Charge	$150	40%	50%
Pontic Porcelain Fused to Metal	$125	No Charge	$140-$240	40%	50%

* Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and PPO contracted fees for non-Delta Dental dentists

** Base or noble metal is the benefit. High noble metal (precious), if used, will be charged to the enrollee at the additional laboratory cost of the high noble metal. (This applies to crowns, bridges, cast and cast cores, inlays and onlays.)

The above is a brief summary of benefits only and not an offer of insurance. Please refer to your Evidence of Coverage for a complete description of benefits and exclusions.

ENDODONTICS	DMO D125H	DMO UNION 1065	HMOCA11A	PPO PLAN	
Root Canal - Anterior	$45	No Charge	$55	20%	50%
Root Canal - Bicuspid	$75	No Charge	$120	20%	50%
Root Canal - Molar	$115	No Charge	$250	20%	50%
DENTURES					
Complete Upper or Lower	$150	No Charge	$145	40%	50%
Partial Upper or Lower	$115	No Charge	$120-$160	40%	50%
Adjust Full Upper or Lower	$0	No Charge	$10	40%	50%
Add Tooth or Clasp	$15	No Charge	$10	40%	50%
Reline Full Upper or Lower	$40	No Charge	$60	40%	50%
PERIODONTICS					
Gingivectomy Per Quadrant	$50	No Charge	$80-$130	20%	50%
Gingivectomy Per Tooth	$35	No Charge	$80-$130	20%	50%
ORAL SURGERY					
Simple Extraction - Single Tooth	No Charge	No Charge	No Charge	20%	50%
Removal of Impacted Tooth (Soft Tissue)	$25	No Charge	$50	20%	50%
ORTHODONTICS					
Start-up Fee	$250	$350	$200	Not Applicable	
Adolescent	$1,895	$750	$1,700	50%, max $2,000	
Adult	$1,895	$750	$1,900	50%, max $2,000	

* Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and PPO contracted fees for non-Delta Dental dentists

** Base or noble metal is the benefit. High noble metal (precious), if used, will be charged to the enrollee at the additional laboratory cost of the high noble metal. (This applies to crowns, bridges, cast and cast cores, inlays and onlays.)

The above is a brief summary of benefits only and not an offer of insurance. Please refer to your Evidence of Coverage for a complete description of benefits and exclusions.

HOW TO FIND A DENTIST

UHC DENTAL DMO D125H:

1. **www.myuhcdental.com**
2. Choose “Find a Dentist”
3. Select Network as “CA Select Managed Care DHMO Plan”
4. Search for Dentist by Location

Start New Search
Where do you work or live? CA
Select a Network CA Select Managed Care DHMO Plan
Search for Dentist
Location
Dentist Name
Practice Name

UHC DENTAL DMO UNION 1065:

1. **www.myuhcdental.com**
2. Choose “Find a Dentist”
3. Select Network as “CA Select Managed Care Direct Compensation”
4. Search for Dentist by Location

Start New Search
Where do you work or live? CA
Select a Network CA Select Managed Care Direct Compensation
Search for Dentist
Location
Dentist Name
Practice Name

DELTA CARE HMO CA11A:

1. **https://www.deltadental.com/us/en/member/find-a-dentist.html**
2. Select Dentist Specialty as “General Dentist”
3. Select Your Plan as “Delta Care USA”
4. Search by Current Location

DELTA PPO PLAN:

1. **https://www.deltadental.com/us/en/member/find-a-dentist.html**
2. Select Dentist Specialty as “General Dentist”
3. Select Your Plan as “Delta Dental PPO”
4. Search by Current Location

VISION

MEMBER ONLY	$8.50
MEMBER + 1 DEPENDENT	$15.50
MEMBER + 2 OR MORE DEPENDENTS	$22.00

BENEFIT	DESCRIPTION	COPAY	FREQUENCY
YOUR COVERAGE WITH A VSP PROVIDER			
WELLVISION EXAM	– Focuses on your eyes and overall wellness	$10 for exam and glasses	Every 12 months
ESSENTIAL MEDICAL EYE CARE	– Retinal screening for members with diabetes – Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. – Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 per screening $20 per exam	Available as needed
PRESCRIPTION GLASSES			
FRAME+	– $220 featured frame brands allowance – $200 frame allowance – 20% savings on the amount over your allowance – $200 Costco® frame allowance – $200 Walmart®/Sam's Club® frame allowance	Combined with exam	Every 12 months
LENSES	– Single vision, lined bifocal, and lined trifocal lenses – Impact-resistant lenses for dependent children	Combined with exam	Every 12 months
LENS ENHANCEMENTS	– Standard progressive lenses – Premium progressive lenses – Custom progressive lenses – Impact-resistant lenses – Average savings of 30% on other lens enhancements	$0 $95 - $105 $150 - $175 $10	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	– $200 allowance for contacts; copay does not apply – Contact lens exam (fitting and evaluation)	Up to $50	Every 12 months
LIGHTCARE™+	– $200 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts	Combined with exam	Every 12 months
EXTRA SAVINGS	**Glasses and Sunglasses** – Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. – 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Routine Retinal Screening** – No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** – Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

YOUR COVERAGE GOES FURTHER IN-NETWORK

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to vsp.com to find an in-network provider. Your plan provides the following out-of-network reimbursements:

- Exam ....up to $45
- Frame ....up to $75
- Single Vision Lenses ....up to $30
- Lined Bifocal Lenses ....up to $50
- Lined Trifocal Lenses ......up to $65
- Progressive Lenses ....up to $65
- Elective Contacts ....up to $105
- Necessary Contacts ...up to $250

†Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.

Classification: Restricted

‡Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
+Coverage with a retail chain may be different or not apply.
VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**.
©2023 Vision Service Plan. All rights reserved.
VSP, Eyeconic, and WellVision Exam are registered trademarks, and VSP LightCare and VSP Premier Edge are trademarks of Vision Service Plan. Flexon and Dragon are registered trademarks of Marchon Eyewear, Inc. All other brands or marks are the property of their respective owners. 102898 VCCM

A CLOSER LOOK AT YOUR VSP VISION COVERAGE

SHOP ONLINE AND CONNECT YOUR BENEFITS.

vsp vision care

Eyeconic® is the preferred VSP online retailer where you can shop in-network with your vision benefits. See your savings in real time when you shop over 70 brands of contacts, eyeglasses, and sunglasses.

WHAT'S INCLUDED WITH ESSENTIAL MEDICAL EYE CARE?

- Fully covered retinal screening for members with diabetes. These high-resolution images of the inside of the eye are a non-invasive way to monitor diabetes.
- Exams and services to treat immediate issues like pink eye and sudden changes in vision.
- Treatment options to monitor ongoing health conditions such as dry eye, diabetic eye disease, glaucoma, and more.

LIGHTCARE™

Why UV and Blue Light Coverage?

- Even if you don't wear prescription glasses, an annual eye exam is an easy and cost-effective way to take care of your eyes and overall health.
- With VSP **LightCare™**, you can use your frame and lens benefit to get non-prescription eyewear from your VSP® network doctor.

Your VSP LightCare Coverage Includes:*

Eye Exam

- A fully-covered WellVision Exam®

Eyewear

Use your frame and lens allowance toward ready-made:

- non-prescription sunglasses or
- non-prescription blue light filtering glasses

MORE WAYS TO SAVE

EXTRA

$20

TO SPEND ON FEATURED BRANDS†

and more

SEE ALL BRANDS AND OFFERS AT VSP.COM/OFFERS.

+

UP TO

40%

SAVINGS ON LENS ENHANCEMENTS‡

WELLNESS PROGRAM

1. Sign up at **join.virginpulse.com**
2. Accept the Terms and Conditions
3. Connect a Fitness Tracker
4. Create Profile and Add Friends
5. Download the App

All members and spouses enrolled in an RSA medical plan are eligible!

YOU CAN EARN **$580 A YEAR** BY TAKING SOME SMALL STEPS THAT LEAD TO BIG CHANGES!

BODY SCAN INTERNATIONAL

Body Scan International offers ONSITE body scanning right on location at the RSA offices! The BSI Body Scan Program is a non-invasive exam that provides a comprehensive, confidential look inside your torso to early-detect, or rule-out, “silent” lesions and anomalies.

As a retiree of RSA, you can take advantage of the RSA discounted rate of $1,140. For more information, or to schedule your appointment, contact BSI directly at 877-274-5577 or go to **healthview.com**.

REMINDERS

- Update Beneficiaries
- Update Contact Information
- Report a Life Event w/in 30 Days
- Call (951) 653-8014

NEW TPA & CONSULTANT

Available for assistance with claims, retiree billing, questions on plans or rates, and Medicare. **949-570-1162**

DID YOU KNOW?

- No ID card is needed for PPO Dental or vision - You only need your SSN
- Everyone in the family can have a different HMO Provider
- The new VSP vision plan offers coverage on non-Rx glasses and sunglasses
- RSA needs to be notified 30 days prior to your Medicare eligibility

HOW TO ENROLL OR MAKE CHANGES

ENROLLMENT/CHANGES INSTRUCTIONS

All Enrollment & Changes are made here: **benefits.plansource.com**

LOGGING IN:

Username: Your username is the first initial of your first name, up to the first six letters of your last name, and the last four digits of your SSN.

For example, if your name is Taylor Williams, and the last four digits of your SSN are 1234, your username would be twillia1234.

Password: Your initial password is your birthdate in the YYYYMMDD format.

So, if your birthdate is June 4, 1979, your password would be 19790604. The first time you log in, you will be prompted to change your password.

OPEN ENROLLMENT:

On the Homepage, click "Get Started" to begin.

BENEFIT CHANGES:

On the Homepage, click "Update My Benefits" to begin.

If you need a password reset or have trouble logging in, please contact our office at: **(951) 653-8014**.

Any OE elections will be effective Jan. 1, 2024 and will continue through Dec. 31, 2024.

OPEN ENROLLMENT CHECKLIST

- ☐ Review 2024 Open Enrollment Booklet
- ☐ Log into PlanSource and Make Changes:
- – Update Contact Information
- – Update Dependent(s)
  - – If Adding or Removing
- – Update Beneficiaries
- ☐ Submit Documentation to Benefit Trust if making Dependent Changes
- ☐ Sign Up for Virgin Pulse
- ☐ Remember to contact the Benefit Trust office 90 Days before your 65th birthday to get switched to Medicare plans!

IMPORTANT CONTACTS

COVERAGE	CONTACT	PHONE	WEBSITE
Medical	Anthem	(800) 227-3771	www.anthem.com
	Kaiser Permanente	(800) 390-3510	www.kp.org
Dental	United Health Care	(800) 228-3384 (800) 999-3367	www.myuhcdental.com
	Delta Dental	(800) 765-6003 (800) 422-4234	www.deltadental.com
Vision	VSP Vision	(800) 877-6372	www.vsp.com
Cancer, Intensive Care, Hospital & Accident	AFLAC Nicki Albright Lisa Coots		nicki_albright@us.aflac.com lisa_coots@aflac.com
CalPERS	CalPERS	(888) 225-7377	www.calpers.ca.gov
Retirement	Nationwide	(877) 677-3678	www.nationwide.com
	Valic	(800) 982-5558	www.corebridgefinancial.com
Wellness Program	VirginPulse	(888) 671-9395	www.virginpulse.com

RSA BENEFITS OFFICE

OFFICE HOURS

Monday: 8 a.m. - 5 p.m.

Tuesday: 8 a.m. - 5 p.m.

Wednesday: 8 a.m. - 5 p.m.

Thursday: 8 a.m. - 5 p.m.

Friday: Closed

Saturday: Closed

Sunday: Closed

MAIN

www.rcdsa.org/benefittrust/

(951) 653-8014

RSABenefits@rcdsa.org

Lauren Driffill, Benefits Manager

lauren@rcdsa.org

THIRD PARTY ADMINISTRATORS

(949) 570-1162

www.unionfirstsolutions.com

EXPLANATIONS OF MEDICAL PLAN OPTIONS

KAISER PERMANENTE

Services must be provided, prescribed, authorized, or directed by a plan physician or facility within the covered service area. A list of covered zip codes is provided in the Kaiser enrollment packet. For members who reside in Coachella Valley and Western Ventura County, you must choose a primary care plan physician within the “affiliated provider” network. For more information, please contact the benefits office. You will have co-payments for approved services. Hospitalization is covered at 100% and there is a co-payment for emergency room visits.

ANTHEM CALIFORNIA CARE/SELECT HMO

Your primary care physician will belong to either a medical group or an IPA. To serve you best, you must live or work within 15 miles or 30 minutes of your medical group. All care, except in a medical emergency, must be provided or authorized by an assigned primary care physician, medical group, or IPA. You will have co-payments for approved services.

Medical Group - A team practice of physicians and health care providers. Most services, including special exams, X-ray and lab tests, are usually available at the medical group’s facility.

Independent Physician Association (IPA) - A medical partnership of physicians who practice in private offices. The IPA physician may refer you to other locations for special services, including special exams, X-ray and lab tests.

ANTHEM EPO (BLYTHE RESIDENTS ONLY)

Since there are no HMO providers in the Blythe Area, you may choose a provider from the Anthem Prudent Buyer network. Most benefits are only payable if you visit an Anthem PPO network health care provider. However, you may receive an exception if Anthem authorizes a referral when there is no Anthem PPO network health care provider within a 25-mile radius of your home who can perform the services you need. It is the member’s responsibility to verify that a provider is an Anthem PPO health care provider.

The Prudent Buyer provider might wait for the Explanation of Benefits (EOB) to determine how to bill you for their services. However, at the time of service, the provider may ask you for payment of your office visit co-payment, plus a percentage of charges that are not covered under your benefits. **When using Non-PPO and Other Health Care Providers for an authorized referral, an emergency, or urgent care, members are responsible for any difference between the allowed amount & actual charges, as well as any deductible & percentage copayment.**

ANTHEM PPO

You may choose to seek services from a PPO (Prudent Buyer) provider from the Anthem network. For these services, you will have a co-payment for your office visits and pay an annual deductible and percentage for other services (i.e., lab work, x-rays, hospitalization). PPO providers bill Anthem for services. You will receive an Explanation of Benefits (EOB) from Anthem determining their payment and your out-of-pocket expenses. You do not need a referral to seek services from a PPO provider.

If you “Opt-Out” and choose a non-network provider, you will likely pay higher out-of-pocket expenses and need to file a claim with Anthem for reimbursement or processing of claims. You will receive an Explanation of Benefits (EOB) from Anthem determining their payment and your out-of-pocket expenses. **When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the allowed amount & actual charges, as well as any deductible & percentage co-payment. You do not need a referral to seek services from a non-network provider.**

ANTHEM BLUE CARD (OUT-OF-STATE) PLAN

You have the option of choosing providers from the PPO (Prudent Buyer) network or Non-PPO providers. For services from a PPO provider, you will have a co-payment for your office visits and pay an annual deductible and percentage for other services (i.e. lab work, x-rays, hospitalization). PPO providers bill Anthem for services. You will receive an Explanation of Benefits (EOB) from Anthem determining their payment and your out-of-pocket expenses.

If you “Opt-Out” and choose a non-network provider, you will likely pay higher out-of-pocket expenses and need to file a claim with Anthem for reimbursement or processing of claims. You will receive an Explanation of Benefits (EOB) from Anthem determining their payment and your out-of-pocket expenses. **When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the allowed amount & actual charges, as well as any deductible & percentage co-payment.**

MEDICARE PLAN OPTIONS

All RSA sponsored medical plans have Medicare plan options available to you and/or your spouse. You will not have to change providers, however a new enrollment application and copy of Medicare card is required. Medicare supplemental plan applications should be submitted to the Benefits Office at least one month before your Medicare effective date. You are required to enroll in Medicare Parts A & B if eligible. **Do not enroll in Part D coverage through Medicare.**

THE HIPAA LAW AND HOW IT AFFECTS YOU

The Federal Health Insurance Portability and Accountability Act (HIPAA), includes a Privacy Rule that establishes safeguards that health carriers, doctors, brokers, and benefits administrators must use to protect the privacy of health information.

The Benefit Trust has put procedures in place to ease your mind. If you have a claims issue, a question as to why a certain procedure or prescription was not covered fully; the Benefit Trust must have you sign an authorization form before the health carrier will release information to us. If you have not already done so and would like to designate a personal representative, please contact the Benefits Office to have a form mailed to you. The personal representative does not need to be enrolled in your insurance coverage but must know your social security number. As always, in emergency situations we will do whatever it takes to get you the care you need.

Your medical, dental and vision plans have phone numbers and Web sites available to retrieve eligibility, benefit and claims information by using a personal pin. To find out more, see Your Contacts on page 25 or log onto **www.rcdsa.org**, and click on Benefit Trust. The carrier links will bring you to the applicable Web sites.

IMPORTANT NOTICES

Effective Date of Notice: September 21, 2023

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

GENERAL PRIVACY RULES

The Board of Trustees, as the Plan Sponsor of the Riverside Sheriffs' Association Benefit Trust Health Plan (the "Plan") is required by law to maintain the privacy of protected health information and to provide you with notice of its legal duties and privacy practices with respect to your protected health information, and to notify you if there is a breach of your unsecured protected health information.

This notice describes the Plan's legal duties and privacy practices including: The Plan's uses and disclosures of protected health information;

Your privacy rights with respect to such information; The Plan's duties with respect to such information;

The person or office to contact for further information about the Plan's privacy practices.

SECTION 1. NOTICE OF USES AND DISCLOSURES

- (a) Required Uses and Disclosures. Upon your request, the Plan is required to give you access to certain protected health information, which includes all individually identifiable health information in order to inspect and copy it. Use and disclosure of your protected health information may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulation
- (b) Uses and disclosures to carry out treatment, payment and health care operations without your consent or authorization. The Plan and its business associates will use protected health information without your consent, authorization or opportunity to agree or object to carry out "treatment, payment and health care operations" as defined below.
  - (i) Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, your pharmacy may contact your treating physician to refill your prescription for medication.
  - (ii) Payment includes but is not limited to actions to make coverage determinations and to provide payment for the treatment you receive (including billing, claims management, Plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may use and disclose your protected health information to tell a doctor whether you are eligible for coverage or what percentage of a bill will be paid by the Plan.
  - (iii) Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts and related business services. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management, and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs and audit the accuracy of its claims processing functions.
- (c) Other uses and disclosures for which consent, authorization or opportunity to object is not required. Use and disclosure of your protected health information is allowed without your consent, authorization or request under the following circumstances:
  - (i) When required by law. The Plan may use and disclose your protected health information when required by law, and when the use or disclosure complies with and is limited to the relevant requirement of such law.
  - (ii) When permitted for purposes of public health activities. For example, PHI may be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
  - (iii) Reports about victims of abuse, neglect or domestic violence to government entities. The Plan will disclose your protected health information in these reports only if the Plan is required or authorized to do so by law, or if you otherwise agree. In such case the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose or reporting child abuse or neglect, it is not necessary to inform the minor that such disclosure has or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's protected health information.
  - (iv) To a public health oversight agencies. The Plan will provide protected health information as requested to government agencies that have the authority to audit our operations. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensures or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
  - (v) When required for judicial or administrative proceedings, provided certain conditions are met. Those conditions include that satisfactory assurances are given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

- (vi) When required for law enforcement purposes. The Plan may release protected health information if asked to do so by a law enforcement official in the following circumstances: (1) to respond to a court order, subpoena, warrant, summons or similar process; (2) to identify or locate a suspect, fugitive, material witness or missing person, (3) to assist the victim of a crime if, under certain limited circumstances, the Plan is unable to obtain the person's agreement, (4) to investigate a death the Plan believes may be due to criminal conduct, (5) to investigate criminal conduct, and (6) to report a crime, its location or victims or the identity, description or location of the person who committed the crime (in emergency circumstances).
- (vii) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- (viii) Organ procurement. The Plan may disclose protected health information to facilitate organ donation and transplantation.
- (ix) Medical research. The Plan may disclose protected health information for medical research projects, subject to strict legal restrictions. (x) When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- (xi) Special government functions. The Plan may disclose protected health information to various departments of the government such as the U.S. military or U.S. Department of State.
- (xii) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

- (d) Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or disclosure. Disclosure of your protected health information to family members, other relatives and your close personal friends is allowed if the information is directly relevant to the family or friend's involvement with your care or payment for that care and you have either agreed to the disclosure or have been given an opportunity to object and have not objected.
- (e) Uses and disclosures that require your written authorization or consent.
  - (i) In general, the Plan will obtain a written authorization before using or disclosing your protected health information whenever it is required to do so under the privacy rules. For example, we will not supply confidential information to another company for its marketing purposes (unless it is for Health Care Operations), for sale (unless under strict legal restrictions), or to a potential employer with whom you are seeking employment without your signed authorization. Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. The Plan may use and disclose psychotherapy notes when needed by the Plan to defend against litigation filed by you. The Plan will not disclose to third parties the results of genetic testing in a manner which includes individually identifying characteristics without your written authorization, nor will it use or disclose your genetic information for underwriting purposes.
  - (ii) The Plan may require your consent to disclose protected health information, even to carry out treatment, payment or health care operations, to certain individuals or organizations. For example, if your union representative is helping you with a claim the Plan may require you to sign a consent form before it will disclose protected health information to that person.
  - (iii) Other uses and disclosures not described in this notices will be made only with your written authorization.
  - (iv) You may revoke an authorization that you previously have given by sending a written request to our Privacy Officer, but not with respect to any actions the Plan has already taken.

SECTION 2. RIGHTS OF INDIVIDUALS

- (a) Right to Request Restrictions on Protected Health Information Uses and Disclosures. You may request the Plan to restrict uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. While the Plan will consider all requests for restrictions carefully, the Plan is not required to agree to your request. However, the Plan must comply with your request to restrict disclosure of your protected health information for payment or health care operations purposes if you paid for these services in full, out of pocket. Such requests should be made to the individual identified in Section 5.
- (b) Right to Receive Confidential Communications of PHI. The Plan will accommodate reasonable requests to receive communications of protected health information by alternative means or at alternative locations. The Plan must agree to your request if you state that disclosure of the information will put you in danger. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your protected health information. Such request should be made to the individual identified in Section 5.
- (c) Right to Inspect and Copy Protected Health Information. Except under certain circumstances limited by law, you have a right to inspect and obtain a copy of your protected health information "in a designated record set" for as long as the Plan maintains the protected health information.

Protected health information" includes all individually identifiable health information transmitted or maintained by the Plan regardless of form.

"Designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analysis and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual. If you request copies of your protected health information, the Plan may charge a reasonable fee to cover the cost.

You or your personal representative will be required to complete a form to request access to the protected health information. Requests for access to protected health information should be made to the individual identified in Section 5. If access is denied, you and your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise rights to review and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

- (d) Right to Amend Protected Health Information. You have the right to request that the individual identified in Section 5 amend your protected health information or a record about you in a designated record set for as long as the protected health information is maintained by the Plan. You or your personal representative will be required to complete a form to request amendment of the protected health information. The Plan may deny your request if you ask us to amend information that: (i) was not created by the Plan, unless the person who created the information is no longer available to make the amendment, (ii) is not part of the protected health information we keep about you, (iii) is not part of the protected health information that you would be allowed to see or copy, or, (iv) is determined by the Plan to be accurate and complete.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

- (e) The Right to Receive an Accounting of Protected Health Information Disclosures. You have the right to request a list of protected health information disclosures, which is also referred to as an accounting.

The list will not include disclosures the Plan has made as authorized by law. For example, the accounting will not include disclosures made for treatment, payment, and health care operation purposes (except as noted in the last paragraph of this subsection (d)). Also, no accounting will be made for disclosures made directly to you or under an authorization that you provided or those made to your family or friends. The list will not include disclosures the Plan has made for national security purposes or law enforcement personnel or disclosures made before April 14, 2003.

The list provided by the Plan will include disclosures made within the last six years (subject to the April 14, 2003 beginning date) unless you specify a shorter period. The first list you request within a 12 month period will be free. You may be charged a reasonable fee for providing any additional lists within a 12- month period.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

You may also request and receive an accounting of disclosures made by the Plan for payment, treatment, or health care operations during the prior three years for disclosures made as of January 1, 2014 for electronic health records acquired before January 1, 2009, or January 1, 2011 for electronic health records acquired on or after January 1, 2009.

- (f) Personal Representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your protected health information or allowed to take any action for you. Proof of such authority may take one of the following forms: (1) A power of attorney for health care purposes, notarized by a notary public, (2) A court order of appointment of the person as the conservator or guardian of the individual, or (3) An individual who is the parent of a minor child.

The Plan retains discretion to deny access to your protected health information to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

- (g) Right to Request a Paper Copy. If you agree to receive this Privacy Notice electronically, you have the right to obtain a paper copy of this Privacy Notice upon request from the individual identified in Section 5.

SECTION 3. THE PLAN'S DUTIES

- (a) General Duty. The Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any protected health information received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Plan still maintains protected health information. The revised notice will be mailed to all active and retired plan participants. Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.
- (b) Minimum Necessary Standard. When using or disclosing protected health information or when requesting protected health information from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the Limited Data Set, or if necessary, the minimum necessary information necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:
  - (i) Disclosures to or requests by a health care provider for treatment;
  - (ii) Uses or disclosures made to the participant or beneficiary;

- (iii) Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- (iv) Uses or disclosures that are required by law; and
- (v) Uses or disclosures that are required for the Plan's compliance with legal regulations.

- (c) De-Identified Information. This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify the individual. In addition, the Plan may use or disclose "summary health information" for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

SECTION 4. YOUR RIGHT TO FILE A COMPLAINT WITH THE PLAN OR THE HHS SECRETARY

If you believe that your privacy rights have been violated, you may file a complaint with the Privacy Officer named in Section 5 below, or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Plan, put your complaint in writing and address it to the Privacy Officer named in Section 5 below. The Plan will not retaliate against you for filing a complaint.

You may also contact the Privacy Officer if you have questions or comments about our privacy practices. You may file a complaint with the Secretary of the U.S. Department of Health and Human Services online at **https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf** or by mailing your complaint to the appropriate the HHS Regional office. The list of regional offices can be found at **http://www.hhs.gov/ocr/office/about/rgn-hqaddresses.html**. If you need help filing a complaint or have a question about the complaint or consent forms, please e-mail OCR at **OCRComplaint@hhs.gov**.

SECTION 5. WHOM TO CONTACT AT THE PLAN FOR MORE INFORMATION

If you have any questions regarding this notice or the subjects addressed in it, you may contact: Riverside Sheriffs' Association

21800 Cactus Ave

Riverside, CA 92518

Office: 951-653-5152

IMPORTANT NOTICE FROM RIVERSIDE SHERIFFS' ASSOCIATION (RSA) ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

This is an annual notice. It is to ensure that active members, retirees and their dependents have this important information. If you are already in enrolled in a Medicare D plan through RSA and do not want to make any changes - no action is needed, your coverage remains the same. If you or a dependent is becoming Medicare eligible in the near future, please remember to contact the RSA Benefits Office at (951) 653-8014 before making any decisions about your coverage.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with RSA and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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. RSA has determined that the prescription drug coverage offered by the Blue Cross of California and Kaiser Permanente is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individual's can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th. Beneficiary's leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your RSA prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with RSA and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact our office for further information contact our insurance brokers, Union First Insurance Solutions at (949) 570-1162. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through RSA changes. You also may request a copy.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE...

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

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

- Date: September 21, 2023
- Name of Entity/Sender: Union First Insurance Solutions
- Contact--Position/Office: Janelle Regan | Administrator
- Address: 18400 Von Karman, Suite 620
Irvine, CA 92612
- Phone Number: (949) 570-1162

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

Under federal law, group health plans, insurers, and HMOs that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery, effective for the first plan year beginning on or after October 21, 1998.

In the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, federal law requires coverage in a manner determined in consultation with the attending physician and the patient, for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Each of the medical plan options available through the Riverside Sheriffs' Association Benefit Trust Health Plan currently covers mastectomies and reconstructive surgery. Coverage is subject to each plan's deductibles, coinsurance and benefit provisions. These provisions are generally described in the Plan Booklet or Explanation of Coverage.

NEWBORN MOTHERS HEALTH PROTECTION ACT

Under the Newborn and Mothers Health Protection Act, the following language is now included in the Health Plan:

The Plan will provide for a hospital stay of no less than 48 hours for the eligible mother and newborn child following a normal delivery and no less than 96 hours for a cesarean birth, unless an attending physician in consultation with the mother approves an earlier discharge. The time periods outlined above begin at the birth of the child. The law also prohibits a plan from requiring health care practitioner to obtain authorization from the Plan for prescribing a length of stay not in excess of those periods.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

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

ALABAMA – MEDICAID
Website: **http://myalhipp.com/** Phone: 1-855-692-5447
ALASKA – MEDICAID
The AK Health Insurance Premium Payment Program Website: **http://myakhipp.com/** Phone: 1-866-251-4861 Email: **CustomerService@MyAKHIPP.com** Medicaid Eligibility: **https://health.alaska.gov/dpa/Pages/default.aspx**
ARKANSAS – MEDICAID
Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – MEDICAID

Health Insurance Premium Payment (HIPP) Program
Website: **http://dhcs.ca.gov/hipp**
Phone: 916-445-8322
Fax: 916-440-5676
Email: **hipp@dhcs.ca.gov**

COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)

Health First Colorado Website: **https://www.healthfirstcolorado.com/**
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: **https://hcpf.colorado.gov/child-health-plan-plus**
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): **https://www.mycohibi.com/**
HIBI Customer Service: 1-855-692-6442

FLORIDA – MEDICAID

Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**
Phone: 1-877-357-3268

GEORGIA – MEDICAID

GA HIPP Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – MEDICAID

Healthy Indiana Plan for low-income adults 19-64
Website: **http://www.in.gov/fssa/hip/**
Phone: 1-877-438-4479
All other Medicaid
Website: **https://www.in.gov/medicaid/**
Phone: 1-800-457-4584

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid Website: **https://dhs.iowa.gov/ime/members**
Medicaid Phone: 1-800-338-8366
Hawki Website: **http://dhs.iowa.gov/Hawki**
Hawki Phone: 1-800-257-8563
HIPP Website: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**
HIPP Phone: 1-888-346-9562

KANSAS – MEDICAID

Website: **https://www.kancare.ks.gov/**
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

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/agencies/dms**

LOUISIANA

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.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – MEDICAID AND CHIP

Website: **https://www.mass.gov/masshealth/pa**
Phone: 1-800-862-4840
TTY: 711
Email: **masspremassistance@accenture.com**

MINNESOTA – MEDICAID

Website: **https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**
Phone: 1-800-657-3739

MISSOURI – MEDICAID

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

MONTANA – MEDICAID

Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**
Phone: 1-800-694-3084
Email: **HHSHIPPProgram@mt.gov**

NEBRASKA – MEDICAID

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

NEVADA – MEDICAID

Medicaid Website: **http://dhcfp.nv.gov**
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – MEDICAID

Website: **https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program**
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
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: **https://www.hhs.nd.gov/healthcare**
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**
Phone: 1-800-699-9075

PENNSYLVANIA – MEDICAID AND CHIP

Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – MEDICAID AND CHIP

Website: **http://www.eohhs.ri.gov/**
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – MEDICAID

Website: **https://www.scdhhs.gov**
Phone: 1-888-549-0820

SOUTH DAKOTA - MEDICAID

Website: **http://dss.sd.gov**
Phone: 1-888-828-0059

TEXAS – MEDICAID

Website: **Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services**
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: **Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access**
Phone: 1-800-250-8427

VIRGINIA – MEDICAID AND CHIP

Website: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select**
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – MEDICAID

Website: **https://www.hca.wa.gov/**
Phone: 1-800-562-3022

WEST VIRGINIA – MEDICAID AND CHIP

Website: **https://dhhr.wv.gov/bms/** **http://mywvhipp.com/**
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – MEDICAID AND CHIP

Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**
Phone: 1-800-362-3002

WYOMING – MEDICAID

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

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

PAPERWORK REDUCTION ACT STATEMENT

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

NOTES

2024 OPEN ENROLLMENT
OCTOBER 1, 2023 – OCTOBER 31, 2023
BENEFITS.PLANSOURCE.COM

Unionfirst