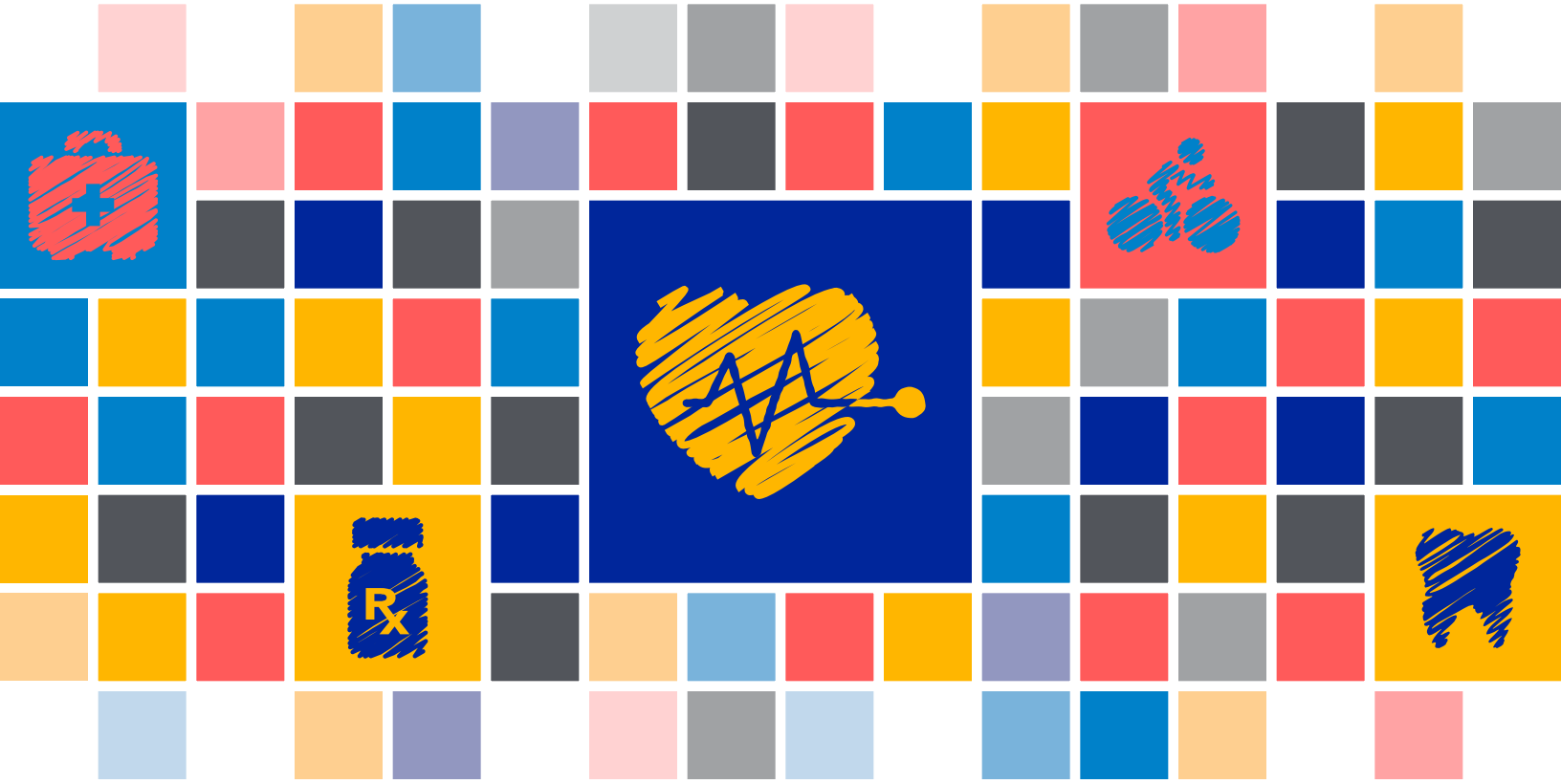
Employee Benefits

2019 Guide



MENDOCINO COUNTY
1850

Employee Benefits Guide 2019

If you (and/or your dependents) have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 31 for more details.

This document summarizes the benefits program. Full details of the benefit plans are contained in the official documents, which will govern in the case of any discrepancies.

Introduction

This Benefits Guide is available to employees to provide a comprehensive resource for the County of Mendocino's (the County) health and welfare benefits. This Guide is not intended to be a contract (expressed or implied), nor is it intended to otherwise create any legally enforceable obligations on the part of the County, its agents, or its employees.

The purpose of this Guide is to summarize the County's employee benefits. For the most detailed and up-to-date information, please refer to the appropriate plan document, evidence of coverage booklet, insurance policy or contract, as well as applicable rules, regulations, resolutions, ordinances and Memoranda of Understanding /Memoranda Agreement.

Benefits described in this Guide are provided by the County for eligible employees and include medical plans, a prescription drug plan, a dental plan, a vision plan, wellness programs, group life insurance coverage, and an employee assistance program. Regular employees may also elect to participate in additional voluntary options at the employee's own expense.

This Benefits Guide also serves as a source for Open Enrollment Information. Each year the County's Health Plan has an open enrollment period that allows for changes to be made to employee Health Plan coverage. The Open Enrollment period is typically the first week in November to the first week in December of each year. During the Open Enrollment period, employees can make changes to their plan without a qualifying event. If you want to make a change to your plan you will need to be sure you are inside the Open Enrollment period window. If you have any questions or need any assistance please contact the Benefits Specialists in HR at the address located in the back of this guide.

These documents can be obtained by contacting the Human Resources (HR) Department and on the County's website located at www.mendocinocounty.org/hr/ehb.

Eligibility

Employees

You are eligible to enroll for coverage under the County of Mendocino benefit plans if you are:

- Actively at work performing the normal job duties at the County's usually place(s) of business, and
- Employed in a permanent position, which is allocated for a minimum of 16 hours/week.

Active Employment

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

- Each day you are actually performing services for the County,
- Each day of a regular paid vacation,
- A regular non-working day, provided you were actively at work on your last preceding scheduled regular working day, and
- Any day on which you were absent from work during an approved leave or solely due to your own health status.

Dependents

When enrolling dependents, proof of dependent status is required by the County and the Health Plan's Third Party Administrator, Delta Health Systems. Proof of dependent status must be provided to Human Resources within 31 days of enrollment of your dependents.

Eligible Dependents

- A legally married spouse
- A registered domestic partner (as defined by the state of residence at the time of the union)
- **A child, up to age 26. For these purposes a "child" will include:**
  - Natural children
  - Stepchildren
  - Legally adopted children (including a child for whom legal adoption proceedings have been started), and
  - Any other child for whom you are required to provide health plan coverage under a Qualified Medical Child Support Order
  - A grandchild, up to age 19 who is mainly dependent on you for care and support, and living with you in a parent-child relationship.
  - A disabled child at any age, as long as he/she continues to meet the following conditions, as defined by Section 12102 of the Americans with Disabilities Act (ADA):
    - A physical or mental impairment that limits one or more major life activities of such individual
    - A record of such an impairment, or
    - Being regarded as having such an impairment

Non-Eligible Dependents

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

Eligibility (continued)

Dual Coverage

If you and your spouse are both eligible for coverage under the County's plan as employees:

- You and your spouse may not be covered as both an employee and your spouse's dependent
- Your dependent children may not be covered by both parents

Change in Dependent Eligibility

It is the employee's responsibility to notify the County Benefit Office within 31 days or sooner of a dependent's change in status that would make the dependent eligible or ineligible for benefit coverage. Some examples of a change in dependent status are birth, death, adoption, divorce, or loss of health coverage from another plan (spouse's); refer to the Plan Document for a more detailed list of qualifying events.

New Hire

As a new hire, to select the coverage you want, you must enroll yourself and your eligible dependents within 31 days of the date you become eligible.

If you do not enroll or provide proof of other qualified group coverage within 31 days, you will automatically be enrolled in Medical Plan II.

Your next opportunity to enroll or change coverage will be during the next annual Open Enrollment period unless you experience a qualified life event.

Enrollment

Enrollment Instructions

When you are hired, you will receive an enrollment form for the Health Plan as well as brochures describing various benefits. You have 31 calendar days to make your choices. Most of your benefits will be effective the first day of the 2nd pay period if you complete and return the enrollment form within 31 days. Read over all of the material carefully. If you have any questions and require assistance in making these important choices, contact the Human Resources office at 707.234.6600.

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

1. Review the information about the medical plans, the health plan comparison, as well as the enrollment packets to determine which medical plan best suits your health and financial needs. If you pay for childcare expenses or day care for an elder dependent, you may be eligible to pay for those expenses with pre-tax dollars by enrolling in the Dependent Care Flexible Spending Plan.
2. Determine your life insurance needs and decide if you wish to purchase additional coverage in addition to that provided by the County.
3. Once you have made your choices, complete the appropriate enrollment forms and turn them in to HR within 31 calendar days of your start date. Be sure to include all your eligible dependents. Remember to complete all beneficiary forms.


County of Mendocino
Health Benefits Enrollment Form

IRS Exemption for Enrolled Health Plan Dependents Who Meet Certain Requirements

The Internal Revenue Service (IRS) offers a tax break for health-related expenses incurred by a "qualifying relative." Under IRS code section 152, a domestic partner (of either gender), a spouse, and children of a domestic partner or spouse qualify for favorable tax treatment if:

- **Partner, spouse or child receives more than half of his or her financial support from the employee, and partner, spouse or child lived with the employee as a member of his or her household for the entire calendar year (January 1** – December 31), with the exception of temporary absences due to vacation, education or military service, and
- Partner, spouse or child is a citizen of the United States, or a resident of the United States, Canada or Mexico.

If an enrolled dependent meets both requirements the employee may submit an annual declaration to the County, and there will be no imputed income for the employer contribution to dependent health premiums and employee premium contributions will be paid pre-tax. To take advantage of this favorable tax treatment, you must file a declaration annually with the County by the required deadlines.

Important Notice

On June 26, 2013, the U.S. Supreme Court ruled that the federal ban on recognizing same-sex marriages was unconstitutional. As a result, same-sex married partners who reside in a state in which same-sex marriage is recognized are legally considered married and are to be treated the same as opposite-sex married partners in all respects under Federal and State law, which means they may now be eligible for benefits to which they were not previously entitled—for example, payment of health insurance premiums on a pre-tax basis, COBRA continuation rights, and other benefits for which spouses are eligible. Any legally married same sex partner should immediately review his or her employee benefits elections to ensure that he or she is maximizing what is now available to same sex marriage partners. The law has not changed with respect to same-sex domestic partners who are not married.

Change in Beneficiaries

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

- Group Life Insurance
- Voluntary Life and AD&D Insurance

Enrollment (continued)

Medical Expense Reimbursement Program (MERP)

The County of Mendocino now offers a new option called the County of Mendocino Medical Expense Reimbursement Program (MERP) as an alternative to the County of Mendocino Medical Plan.

MERP allows you, your spouse and your dependents to leave your current group plan and join your spouse's plan. MERP will cover the difference between the monthly amount you pay for the County's Health Plan and the monthly amount your spouse will pay to add you and your dependents to their plan. MERP will also pay 100°/o of copays, deductibles and coinsurance for you and your dependent children, up to a pre-determined maximum amount. Your cost to participate in this plan, if you are eligible, is generally less than your current Medical Plan.

Claims

MERP is administered by J&K Consultants, who has a dedicated staff to personally handle your claims and reimbursements. Any paper claims can be submitted by fax, email, or by US mail. Claim forms are available from J&K Consultants. If you have questions regarding claims or benefits, please call J&K Consultants at 877.872.4232 or email: merp@jandkcons.com.

Medical

The County offers two different medical PPO plans. Both plans offer broad, comprehensive protection to cover a wide range of medical providers, services and supplies which includes prescription drug coverage.

A PPO plan allows you to receive medical care and services from any physician or facility you choose. As a PPO plan participant, you do not need to select a primary care physician, nor do you need referrals for a specialist.

The County of Mendocino partners with Delta Health Systems to be our Third Party Administrator (TPA) for the employee benefit plan. As our TPA, Delta Health Systems processes claims on the County's behalf and performs other administrative services in accordance with our Summary Plan Description (SPD) or Health Plan rules. They have a long-standing provider network relationship with Anthem Blue Cross which allows us to utilize the Anthem Network of Providers for our in-network providers.

There are two types of providers:

- **In-Network Providers.** Anthem Blue Cross physicians and hospitals which have agreed to provide care to members at a lower negotiated rate. If you use in-network providers, benefit coverage will be greater and your out-of-pocket costs will be lower.
- **Out-of-Network Providers.** Any provider not affiliated with Anthem Blue Cross. If you obtain care from an out-of-network provider, your benefit coverage will be lower and out-of-pocket costs will be higher.

In most cases, benefits are subject to either:

- **Coinsurance (%).** The amount you pay after services or care has been received and the plan has paid its share. A percentage, as listed in the benefit chart, of the in-network negotiated charges.
- **Copay ($).** The amount you pay the provider at the time care or services are received. A set dollar amount, as listed in the chart.

If you have any questions as to whether a particular medical procedure is covered under current standards, you should always check before incurring the expense, even if pre-authorization is not required.

- **Mandatory Pre-Authorization.** Care received from out of state providers requires pre-authorization. It is the employee's or covered person's responsibility to make certain that required pre-authorization is obtained.

Medical (continued)

Plan Benefits	Plan 1		Plan 2	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Plan Maximum	Unlimited		Unlimited	
Annual Deductible	$350/$1,050		$500/$1,500	
Annual Out-of-Pocket Limit	$3,000/$6,000		$4,000/$8,000	
Unless indicated otherwise (Ded. Waived), all benefits are subject to the Deductible.				
Physician Care				
• Office Visits	85%	70%	80%	60%
Preventive Outpatient Services				
• Adult Periodic Exams	100% (Ded. Waived)	70%	100% (Ded. Waived)	60%
• Well- Child Care	100% (Ded. Waived)	70%	100% (Ded. Waived)	60%
• Immunizations	100% (Ded. Waived)	70%	100% (Ded. Waived)	60%
• Well-Woman Exams	100% (Ded. Waived)	70%	100% (Ded. Waived)	60%
• Mammograms	100% (Ded. Waived)	70%	100% (Ded. Waived)	60%
Diagnostic X-ray and Lab Tests	85%	70%	80%	60%
Pregnancy and Maternity Care (Pre-Natal)	85%	70%	80%	60%
Inpatient Hospital/Surgical Services				
• Inpatient Hospitalization	85%	70%	80%	60%
• Outpatient Facility Charge	85%	70%	80%	60%
• Ambulance	85%	70%	80%	60%
Emergency Room Services				
• Emergency Room*	85%	70%	80%	60%
Mental Health Benefits				
• Outpatient Services	85%	70%	80%	60%
• Substance Abuse	85%	70%	80%	60%
Other Services and Supplies				
• Durable Medical Equipment	85%	70%	80%	60%
• Home Health Care	85%	70%	80%	60%
• Skilled Nursing or Extended Care Facility	85%	70%	80%	60%
• Chiropractic Services	85%	70%	80%	60%
• Outpatient Rehabilitation Therapy (Physical, Occupational, Speech)	85%	70%	80%	60%

* $50 Emergency Room copay to be collected at time of service (copay waived if admitted).

Medical (continued)

Mandatory Pre-Authorization – Care or Services	Timeframe
Inpatient Hospital Stays	
• Scheduled or non-emergency admissions	Five business days prior to admission
• Non-scheduled emergency admissions	Within 48 hours of admission
• To continue a stay beyond the period certified	Before the original timeframe expires
Other Care, Treatment of Admission	
• Second surgical opinions	Prior to care, treatment or admission
• Surgical procedures performed in a hospital outpatient department or freestanding surgery center	Prior to care, treatment or admission
• Ambulance transport (non-emergency)	Prior to care, treatment or admission
• All elective inpatient hospitalization	Prior to care, treatment or admission
• Durable medical equipment in excess of $2,000	Prior to care, treatment or admission
• Outpatient IV Therapy in hospital setting	Prior to care, treatment or admission
• Non-participating consultations	Prior to care, treatment or admission
• Transplant(s)	Prior to care, treatment or admission

Claims

Send California Medical Claims to:

Anthem Blue Cross, PO Box 60007, Los Angeles, CA 90060-0007

PlushCare

PlushCare gives you remote access to a network of doctors so you can receive quality medical care without the unnecessary hassle of visiting a physician's office. PlushCare's network of doctors are available online or over the phone and provide treatments for hundreds of conditions. If appropriate, the doctor can write a prescription and have it sent immediately to the pharmacy of your choice. You and your family no longer have to wait to get the care you need!

PlushCare treats hundreds of conditions, including:

- Bronchitis
- Chickenpox
- Ear Infections
- Impetigo
- Kidney Infections
- Lice
- Pink Eye
- Pneumonia
- Pre-travel Questions and Prescriptions
- Rashes/Dermatitis
- Sinus Infection (Sinusitis)
- Sore Throat
- STD Testing and Treatment
- Strep Throat
- The Common Cold and Stomach Flu
- Urinary Tract Infection
- And More!

Medical (continued)

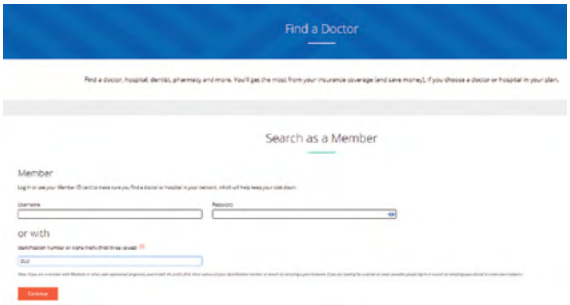
Locate a Preferred Provider

To find a provider anywhere (within the Anthem Blue Cross Network):

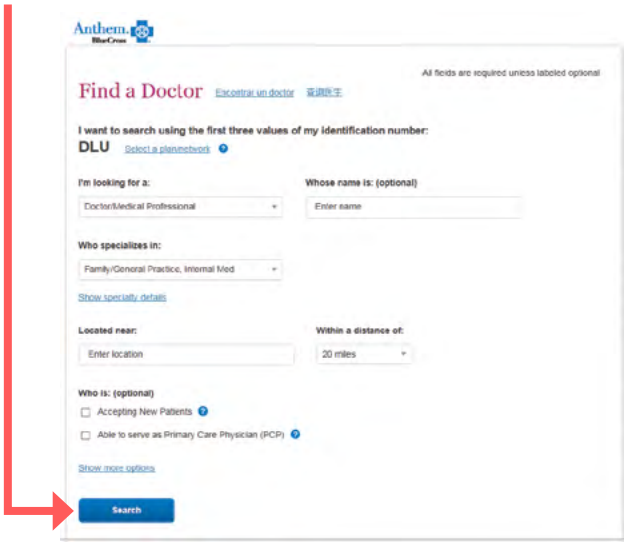
1. To get started, go to the County of Mendocino Website: www.mendocinocounty.org/hr/ehb
2. Click on "Medical Coverage" under Employee Health Insurance

3. Click on the Anthem "Find an In Network Provider" graphic located on the right sidebar.

4. Enter the letters "DLU" in the "Identification Number or Alpha Prefix (first three values)" field.



5. Enter the type of provider you are looking for from the drop down box.
6. Enter the area the provider specializes in from the drop down box.
7. Enter your zip code and choose the distance you are willing to travel.
8. If you are looking for a particular provider, enter the name, if you know the correct spelling, in the "Whose name is" field (optional).
9. Click "Search" to see the results.



Pharmacy

Our pharmacy benefit is provided through Express Scripts, Inc. Every day, Express Scripts, Inc. handles more than a million prescriptions through their networks of retail pharmacies and home delivery facilities. On the receiving end are tens of millions of individuals who count on Express Scripts, Inc. and their plan sponsors to provide a sound pharmacy benefit today and into the future.

The County of Mendocino encourages you to take advantage of the generic equivalent to your medication whenever possible. The more money we save individually on medications, the more money we save collectively with the potential to possibly avoid higher health care premium increases.

Prescription Drugs	Plan 1 and Plan 2	
	In-Network	Out-of-Network
Retail (up to 30 days supply)		
• Generic	Greater of 10% or $10 copay	Not covered
• Brand (Formulary/Preferred)	Greater of 20% or $20 copay	Not covered
• Brand (Non-Formulary/Non-Preferred)	Greater of 30% or $30 copay	Not covered
Mail Order (up to 90 days supply)		
• Generic	$20 copay	Not covered
• Brand (Formulary/Preferred)	$40 copay	Not covered
• Brand (Non-Formulary/Non-Preferred)	$60 copay	Not covered

Note: Using preferred drugs helps control costs for you and your plan while still providing you with the medications you need to stay healthy.

Retail Pharmacy

This is the right choice for prescription drugs that you take on a short term basis, such as an antibiotic used to treat strep throat.

Express Scripts Pharmacy

This is the right choice for medications that you take on a regular basis, such as those used to treat high blood pressure.

NOTE

The first three times you purchase certain long term drugs through your local retail pharmacy, you will pay your regular retail copay. After that, you will pay a higher copay for those long term drugs unless you choose to order them through Express Scripts Pharmacy

For Pharmacy Claims

Express Scripts, Inc., 800.711.0917

www.express-scripts.com

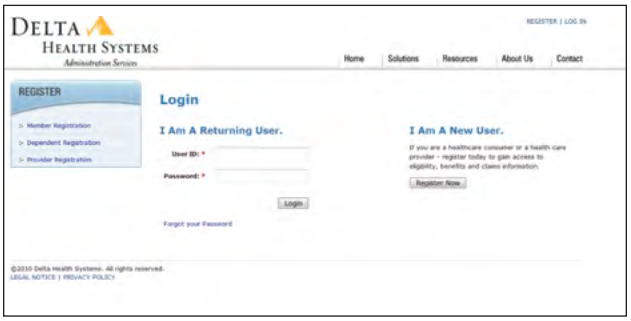
Medical/Pharmacy Websites

Delta Health Systems Website

Delta Health Systems offers a secure, dynamic website that allows you to access your health care information anytime while also keeping your individual claims data strictly confidential. No diagnosis or procedure information is ever displayed.

The website allows you to:

- Check the status of a claim
- Verify eligibility
- Print claim forms, Explanation of Benefits (EOB), Third Party Liability Forms, Workers' Compensation Questionnaires
- View plan benefits online
- Print a temporary identification card
- Contact customer service



Easy Access Instructions

1. Go to www.deltahealthsystems.com
2. Select "Member" then select "Click Here" to log in or register.
3. If you are not already a registered user, please complete the required fields after selecting "Register" and click submit.
4. You will receive an automatic email confirming that you are now a registered user.
5. Once you have registered, return to the website listed above and select "Login".
6. Enter your User ID and Password (forgot your "User ID" or "Password"? Click on the "Log In" button on the Home Screen).

Access to Dependent Information

Due to HIPAA regulations, you must register your dependents separately in order to view claims and eligibility, unless your dependent has e-signed a HIPAA authorization release form. Please select "Dependent Registration· and follow the prompts.

Please note, only claims administered by Delta Health Systems can be viewed on the website. Historical claims processed by a previous Third Party Administrator (TPA) are not available.

Medical/Pharmacy Websites (continued)

Express Scripts Website

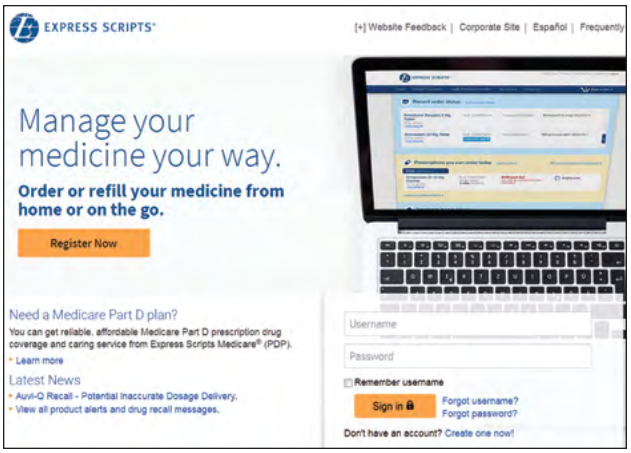
At express-scripts.com, your information is secure and confidential. Registering is safe and simple. Please have your member ID and a recent prescription number available.

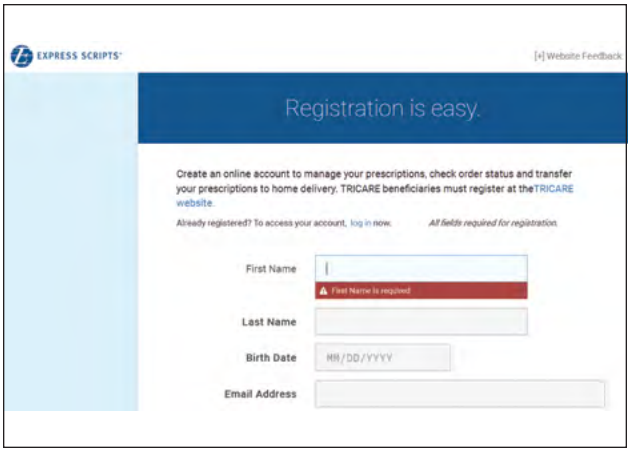
The website provides a fast, easy way to manage your prescription and costs and allows you to:

- Refill and renew prescriptions for you and your family
- Find potential lower-cost options using My Rx Choices®
- Track your prescriptions and mail order refills
- Receive alerts online if there is a risk of a medication-related safety issue
- Contact a pharmacist anytime, day or night
- Locate a participating retail pharmacy in your area
- Review your plan's coverage guidelines
- View claims, balances and prescription history

Access to Express Scripts

1. Go to express-scripts.com and click "Register Now" or "Sign In."
2. Enter Information about yourself, including your name, date of birth, and member ID number
3. Provide an email and password
4. Enter a password hint (in case you forget your password) and a secret question and answer (for added security)
5. Click "Register Now" and you're done
6. For additional information, click on the "Help" links or call 800.711.0917





Dental

The County offers a comprehensive dental plan through Delta Dental of California who has been offering quality, value-based dental benefits coverage for more than 50 years. The Delta Dental plan allows you to go to any provider you choose, however, you may have a lower out-of-pocket cost when utilizing a Delta Dental network provider. Reimbursement is based on the following:

- PPO contracted fees for PPO Dentists
- Delta Dental Premier contracted fees tor Premier Dentists
- The program allowance for non-Delta Dental dentists

The County recommends that a dental pre-treatment estimate be obtained for dental work if the cost is more than $350. Most dental offices are familiar with pre-treatment procedures and will be able to provide one to you.

Dental Summary

Type of Benefits	In-Network PPO/Premier Reimbursement (negotiated fee schedule)	Out-of-Network
Deductible	$25/$75 for family	$25/$75 for family
Calendar Year Maximum	$1,500/person	$1,500/person
Preventive	100%	100% of UCR
Exams and Cleanings	Twice per calendar year	Twice per calendar year
Fluoride (children 17 and younger)	Twice per calendar year	Once per calendar year
Full Mouth X-ray Series or Panoramic X-ray	Once every five (5) years	Once every five (5) years
Bitewing X-rays	Twice per calendar year	Twice per calendar year
Sealants (children 15 and younger)	Limited to once per tooth	Limited to once per tooth
Fillings	85%	85% of UCR
Oral Surgery	85%	85% of UCR
Endodontics/Root Canals	85%	85% of UCR
Periodontic Treatment	85%	85% of UCR
Extractions	85%	85% of UCR
Major Restorative	50%	50% of UCR
Inlays	50%	50% of UCR
Crowns	50%	50% of UCR
Fixed Bridges	50%	50% of UCR
Dentures	50%	50% of UCR

Send Dental Claims to:

Delta Dental, PO Box 997330, Sacramento, CA 95899-7330

800.765.6003, www.deltadentalins.com

Vision

The County offers a vision plan through VSP to help you see well, stay healthy, and maximize your individual potential. Founded in 1955 with a dream of providing high-quality, cost-effective eye care benefits, VSP Vision Care is the largest vision benefits company in the United States. More than 60 years later, they offer world-class services to more than 77 million members.

The County of Mendocino recommends utilizing network providers to realize the largest savings possible.

Vision Summary

Eligible Expenses	Frequency	In-Network	Out-of-Network
Eye Exam	Every calendar year	$25 copay	Up to $45 allowance
Contacts (in lieu of Glasses)			
• Elective	Every other calendar year	$0 copay up to $110 allowance	Up to $95 allowance
• Medically Necessary (as defined below)	Every other calendar year	$25 (no maximum)	Up to $210 allowance
Prescription Glasses	Every other calendar year	$25 copay	Subject to allowance
• Single Vision Lenses	Every other calendar year	Included	Up to $30 allowance
• Bifocal Lenses	Every other calendar year	Included	Up to $50 allowance
• Trifocal Lenses	Every other calendar year	Included	Up to $60 allowance
• Basic Progressive	Every other calendar year	Up to $55 allowance	Not available
Lens Options			
• Basic Polycarbonate	Every other calendar year	Up to $31 allowance (children covered at 100%)	Not available
• Standard Anti-Reflective	Every other calendar year	Up to $41 allowance	Not available
Frames	Every other calendar year	$110 allowance	Up to $50 allowance
• Featured Frame Brands	Every other calendar year	$130 allowance	Up to $50 allowance

Medically Necessary Contacts

Contact lenses will be considered medically necessary only if prescribed for one of the following situations:

- Your vision cannot be corrected to 20/70 in the better eye except by the use of contact lenses
- You need contact lenses after cataract surgery
- You are being treated for a condition such as Keratoconus or Anisometropia and contact lenses are routinely used as part of the treatment.

Send Vision Claims to:

VSP, PO Box 385018, Birmingham, AL 35238-0518

800.877.7195, www.vsp.com

Basic Life and AD&D and Air Ambulance

Mutual of Omaha – Basic Life Insurance

The County provides a Basic Life and Accidental Death & Dismemberment (AD&D) benefit at no cost to the employee if you are enrolled in the Health Plan. The plan will pay the following amount to your beneficiary at the time of death:

- $50,000 for
  - Department Heads and Elected Officials
  - DSA
  - MCLEMA
  - MCPAA
  - Unrepresented
- $20,000 for:
  - Management Association
  - MCACE
  - SEIU
  - MCPEA

Mutual of Omaha – Accidental Death and Dismemberment (AD&D)

If you have an accident while covered under this plan you or your beneficiaries may be eligible for additional coverage. The amount of coverage is based on the type of loss and dependent on your bargaining group or union listed below:

- Up to $50,000 for
  - Department Heads and Elected Officials
  - DSA
  - MCLEMA
  - MCPAA
  - Unrepresented
- Up to $20,000 for:
  - Management Association
  - MCACE
  - SEIU
  - MCPEA

Don't Forget to Name a Beneficiary

A beneficiary is the person or persons who will be paid if you die while covered by the plan. A person becomes your beneficiary only if you have named them when you enrolled. If you are married and not naming your spouse as the beneficiary, your spouse must sign an acknowledgement with a community property consent.

AirMedCare Network – Air Ambulance

Enrollment in the County's Health Plan also provides coverage for air ambulance services. AirMedCare Network is an alliance among several air ambulance providers including CalStar and Reach, both of whom have bases in Mendocino County. This program allows you to receive air ambulance service with no coinsurance amount. CalStar and Reach as well as any provider in the network agree to accept only the payment made by the County's Health Plan.

If you have declined enrollment in the County's Health Plan because you have other group coverage, you may purchase Air Ambulance membership by contacting AirMedCare Network directly.

Rates

Coverage Category	Bi-Weekly Rates Effective January 1, 2019					
	Employee Only	Employee & Spouse	Employee & Children	Employee, Spouse & Child	Employee & Domestic Partner	Employee, Child & Domestic Partner
Plan 1						
• Employee Cost Pre-Tax	$120.37	$263.76	$209.83	$358.96	$120.37	$215.57
• Employee Cost Post-Tax					$143.39	$143.39
• Total Employee Cost	$120.37	$263.76	$209.83	$358.96	$263.76	$358.96
• Employer Cost	$361.10	$791.30	$629.51	$1,076.87	$791.30	$1,076.87
• Total Plan Cost	$481.47	$1,055.06	$839.34	$1,435.83	$1,055.06	$1,435.83
Plan 2						
• Employee Cost Pre-Tax	$76.04	$169.39	$135.51	$232.77	$76.04	$139.42
• Employee Cost Post-Tax					$93.35	$93.35
• Total Employee Cost	$76.04	$169.39	$135.51	$232.77	$169.39	$232.77
• Employer Cost	$228.13	$508.16	$406.52	$698.31	$508.16	$698.31
• Total Plan Cost	$304.17	$677.55	$542.03	$931.08	$677.55	$931.08

Coverage Category	Wellness Bi-Weekly Rates Effective January 1, 2019**					
	Employee Only	Employee & Spouse	Employee & Children	Employee, Spouse & Child	Employee & Domestic Partner	Employee, Child & Domestic Partner
Plan 1						
• Employee Cost Pre-Tax	$94.05	$237.44	$183.51	$332.64	$94.05	$189.25
• Employee Cost Post-Tax					$143.39	$143.39
• Total Employee Cost	$94.05	$237.44	$183.51	$332.64	$237.44	$332.64
• Employer Cost*	$387.42	$817.62	$655.83	$1,103.19	$817.62	$1,103.19
• Total Plan Cost	$481.47	$1,055.06	$839.34	$1,435.83	$1,055.06	$1,435.83
Plan 2						
• Employee Cost Pre-Tax	$49.72	$143.07	$109.19	$206.45	$49.72	$113.10
• Employee Cost Post-Tax					$93.35	$93.35
• Total Employee Cost	$49.72	$143.07	$109.19	$206.45	$143.07	$206.45
• Employer Cost*	$254.45	$534.48	$432.84	$724.63	$534.48	$724.63
• Total Plan Cost	$304.17	$677.55	$542.03	$931.08	$677.55	$931.08

* Includes $26.32 Wellness Incentive Credit from Trust Fund

** See page 25 for details on how to qualify for the discounted Wellness Bi-Weekly Rates

Open Enrollment

Open Enrollment Period

Our Health Plan contracts allow one opportunity each year during Open Enrollment for eligible County employees to make new decisions about health coverage for themselves and their dependents. This is also your opportunity to enroll or re-enroll in a medical and/or dependent care flexible spending account or other voluntary benefits.

The Open Enrollment period typically begins the first week of November and runs for at least 30 days. Most changes made during the open enrollment period are effective January 1.

Any applicable forms needed to make changes to your benefits MUST be received by the Human Resources Office before 5:00 p.m. on the Open Enrollment deadline.

Open Enrollment Fairs

The County of Mendocino Human Resources is excited to host Open Enrollment benefit fairs in the fall of each year. These fairs are a great way for County employees and their family members to learn valuable information by attending fun, benefit-focused events in Fort Bragg, Willits and Ukiah.

The Open Enrollment fairs typically take place during the first week of November each year. Dates, times and locations are announced at least 30 days in advance. These fairs kick off the Health Plan's Open Enrollment period and are attended by the County's Health Benefits team, along with a variety of Health Plan vendors.

PLEASE NOTE

If you participated in the Flexible Spending Plan and wish to participate again at the start of the new year, or if you want to participate for the first time*, you must complete an enrollment form for the new plan year. When you've completed the enrollment form, return it to Human Resources before Open Enrollment ends.

Transitioning to Medicare after Retirement

If you are eligible to participate in the County medical plans as an active employee and wish to continue working after reaching age 65, you have important options to consider when approaching Medicare eligibility. While you are still an active benefited employee under a County medical plan, you may be able to delay enrollment in some parts of Medicare without incurring a late enrollment penalty at a later date. Your County active medical plan remains primary to Medicare while you are working. If you are within three (3) months of retirement, please contact Human Resources for information on Retiree medical benefits. For details of what's covered under Medicare, how to enroll, and your options regarding Medicare coverage, contact your local Social Security office or visit on the web.

For information on how to enroll in Medicare, please visit www.medicare.gov. For information on Medicare Part D, please visit www.medicare.gov/part-d/.

* Employees must complete the initial one year probationary period to be eligible for participation in the Flexible Spending Plan.

Changes in Coverage

Qualifying Event

You may experience certain events during the plan year that would allow you to change your or your dependent's medical coverage. If any of the following events occur, you must change your benefit coverage within 31 days of the event:

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

Special Enrollment Rights as Provided by HIPAA

You initially declined coverage under the plan because you had coverage under another plan, and subsequently incurred a loss of coverage under the other plan.

Occurrence of certain events such as birth, adoption, placement for adoption or marriage; eligibility for state premium subsidies under the Children's Health Insurance Program or State Children's Health Insurance Program Loss of coverage under Medicaid, the Children's Health Insurance Program or State Children's Health Insurance Program.

Voluntary Plans

The County of Mendocino recognizes that your benefits are an important part of the reason you choose to work here. The County provides a variety of high quality benefits, largely paid for by the County or at a reasonable cost to you. You can also choose between different optional benefits to meet your individual and family needs.

Payroll Deductions	Vendor Name	Benefit Offered
Yes	Mutual of Omaha	Voluntary Life Insurance
Yes	Mutual of Omaha	Accidental Death & Dismemberment
No	AirMedcare Network (CalStar/REACH)	Air Ambulance Service based in Ukiah and Willits
Yes	Liberty Mutual	Auto, Home and Life
Yes	Aflac	Accident. Life, Disability, Dental, Critical Illness, Hospital Indemnity
Yes	MassMutual	Retirement Planning, Deferred Compensation Plans
No	CalPERS	Long Term Care
Yes	CalPERS - 457 Plan	Supplemental Income, Deferred Compensation Plans

Mutual of Omaha – Voluntary Term Life Insurance

Employee

As a County employee you have the opportunity to gain greater financial security for yourself and your family members by supplementing your County paid Basic Life Insurance coverage.

To be eligible for coverage without evidence of insurability (health/or physical exam) up to $200,000 you must enroll yourself and your dependents within 31 days of being eligible for coverage.

Coverage is purchased in units of $10,000. You can apply for as many units as you want up to a maximum of 5x your base salary rounded to the next $10,000 or $500,000, whichever is less.

You must be enrolled in voluntary coverage in order to cover your dependent(s).

Spouse

Coverage for your spouse can be purchased in units of $5,000 up to a maximum of 100% of employee benefit or $500,000 (with a guarantee issue amount of up to $30,000). Spouse coverage ends at age 70.

Children

Coverage for your child(ren) can be purchased in units of $1,000 from a minimum of $2,000 up to a maximum of $10,000 for unmarried children age 14 days to 21 years (or to age 25 years if student). One monthly premium will insure all your eligible children regardless of the number of children you have.

Voluntary Plans (continued)

Mutual of Omaha – Voluntary AD&D Insurance

Upon enrollment of Voluntary Term Life Insurance through Mutual of Omaha, you will automatically receive full 24-hour accident protection anywhere in the world, on or off the job, on business, vacation, or at home. Please note, you cannot purchase this coverage as a stand-alone policy.

Coverage is automatically the same amount as your Voluntary Term Life Insurance policy through Mutual of Omaha.

For you, your spouse and your dependent child(ren):

The Principle Sum amount is equal to the amount of the life insurance benefit. AD&D coverage is available if you or your dependents are injured or die as a result of an accident, and the injury or death is independent of sickness and all other issues. The benefit amount depends on the type of loss incurred, and is either all or a portion of the Principle Sum.

One monthly premium will insure all your eligible children, regardless of the number of children you have. You must be covered in order to have coverage for your children.

Liberty Mutual – Auto and Home Insurance

Liberty Mutual offers employees exclusive savings on quality auto, home, and life insurance. Along with a 12-month rate guarantee and multi-policy discount, their unique benefits include Better Car Replacement™ and Home Protector Plus™.

Aflac – Accident, Life, Disability, Dental, Critical Illness, Hospital Indemnity and More

Aflac offers supplemental voluntary insurance for daily living. It pays cash benefits directly to you (unless otherwise assigned) to help with daily expenses when you're sick or hurt regardless of what your health plan pays.

MassMutual – Retirement Planning and Tax Deferred Compensation Plans

MassMutual offers you a supplemental retirement 457 Deferred Compensation Plan as a benefit to help you save and invest for retirement. Your retirement plan offers a variety of investment options, covering a range or risk levels and investment objectives. By preparing today, you have more choices for your life tomorrow.

CalPERS – Supplemental Income Plan and 457 Deferred Compensation Plans

For more than a decade, CalPERS has been offering a Deferred Compensation Plan to local public employers and their employees. Their commitment to provide financial security, value, low cost and quality customer service to employers and plan participants is the base of the CalPERS program. The CalPERS 457 Plan is designed specifically for public employees to help supplement their retirement savings.

Long Term Care

Long-term care (LTC) coverage helps pay for the high cost of care when you need assistance with the activities of daily living. CalPERS LTC is an optional, employee-paid benefit available to all current and former members (including retirees) and their eligible family members. With CalPERS Long-Term Care coverage, you have flexibility to receive the care you need.

AirMedCare Network – Air Ambulance

If you have declined enrollment in the County's Health Plan because you have other group coverage, you may purchase Air Ambulance membership by contacting AirMedCare Network directly.

See Contact page at the end of this Employee Benefits Guide for phone number and website information.

Flexible Spending Accounts

The Flexible Spending Plan is available to employees who are eligible for the Health Plan and have passed their initial employment probationary period. The Flexible Spending Plan allows you to save money by using pre-tax dollars to pay for unreimbursed health and dependent care expenses. Many employees and their families are able to increase their take home pay by using this program. Flexible Spending Accounts (FSAs) help you to save money by offering you the ability to set aside money on a pre-tax basis. The types of flexible spending accounts for which you can enroll, if eligible, are Health Care Spending Account and Dependent Care Spending Account.

Health Care Account (HCA)

Although medical, vision and dental plans pay for many of your health care expenses, not all of your bills will be covered. You can pay for those expenses that are not covered through your Health Care Flexible Spending Account (HCA). Important: Medical expenses incurred by or on behalf of domestic partners (and their children) that are not qualifying dependents under Internal Revenue Code Section 152 are not eligible for tax-free reimbursement from an HCA. Questions surrounding HCAs as they relate to domestic partners are complex and should be referred to an attorney.

Your HCA can be used to reimburse:

- your own health care expenses, and
- health care expenses incurred by your spouse and other eligible dependents, even if they are not covered by another health care plan.

Eligible dependents include those individuals:

- that you claim as dependents on your federal income tax returns,
- that your ex-spouse has the right to claim as dependents for income tax purposes, or
- whose primary residence is your home.

Dependent Care Account (DCA)

This account provides a way for you to accumulate pre-tax funds to reimburse yourself for childcare expenses or for daycare expenses for a disabled dependent. Eligible expenses are those that would qualify for a child care tax credit on your federal income tax return. These services may be provided inside or outside your home by babysitters, companions or eligible day care centers. Services, however, may not be provided by someone you claim as a dependent on your tax return or by your child under the age of 19. The following types of dependent day care expenses are eligible for reimbursement through this account:

- summer day camp,
- pre-school,
- day care center,
- before- or after-school care,
- care provided inside or outside your home by anyone other than your spouse or your dependents,
- a nurse or caregiver for an elderly relative, and
- services of a housekeeper whose duties include, in part, providing for a qualified dependent.

Examples of eligible and ineligible Medical Expenses can be found on page 24 of this document. For a complete list of eligible health care and dependent day care expenses, you can review the IRS' website at www.irs.gov or ask for Publication 503 from your local IRS office or contact Delta Health Systems.

Flexible Spending Accounts (continued)

How to Enroll in the Program

Each year during Open Enrollment, (typically held in the fall) you have the opportunity to put aside pre-tax dollars by completing a Flexible Spending Plan Enrollment form and a Salary Redirection Agreement (samples on page 24 of this book) into one or both of the two Flexible Spending Accounts:

- **Health Care Account:** Used to pay for eligible family medical expenses
- **Dependent Care Account:** Used to pay for child or adult day care expenses

You can fund your account with pre-tax salary contributions which are automatically withdrawn from your bi-weekly pay check based upon your election amount. In order to determine the amount that will be withdrawn per pay period, just take the total amount that you want to contribute and divide it by 26 (the number of pay periods per year).

example

Annual Contribution
$1,300 ÷ 26 pay periods

$50.00

per pay period deduction

Note: Enrollment forms are available in the Human Resources office. Forms can also be obtained by utilizing the HR Forms icon on the Human Resources website.

Contribution Limits

The following chart provides contribution amounts for the plan year (January 1 through December 31).

Plan Year 2019	Max Plan Year Contribution	Min Plan Year Contribution
Health Care	$2,700*	$100
Dependent Day Care	$5,000**	$100

* Additional limitations apply if you are married; refer to the section below for additional information.

** This limit may be indexed for inflation each year (a type of cost-of-living index).

Additional Limitations if You are Married

The following limits also apply to the Dependent Care Flexible Spending Account if you are:

- married and file a joint tax return, you and your spouse may contribute only a combined total of $5,000;
- file separately, you and your spouse may contribute only $2,500 each;
- your spouse earns less than $5,000, you cannot be reimbursed for more than your spouse's earned income (unless your spouse is disabled or a full-time student); and your spouse is disabled or a full-time student, he or she will be treated as earning an annual income of $2,400 ($4,800 if you are caring for two or more dependents, including your spouse).

Penalty for Reimbursement of Non-Eligible (Non-Qualified) Expenses

Reimbursements for non-qualified expenses are subject to a 20% penalty and taxed at the accountholder's tax rate.

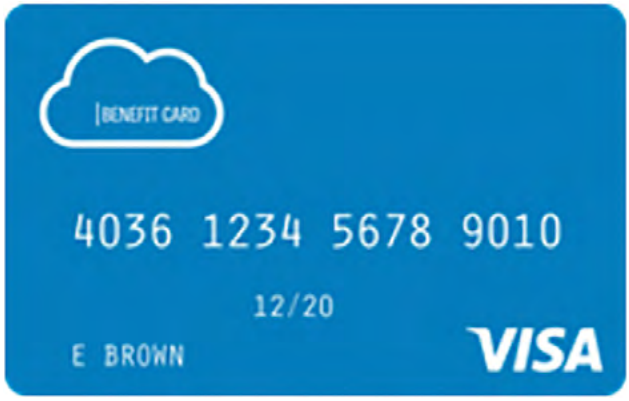
Flexible Spending Accounts (continued)

Accessing the Funds in Your Account

There are three ways to use your Account:

1. **Prepaid Benefits Card** – No Claim Submission: The Card lets you electronically access the pre-tax amounts set aside in your Flexible Spending Account. The Card works like a MasterCard or Visa; when you have eligible expenses at a facility or pharmacy that accepts MasterCard or Visa, simply use your card. Claims do not need to be submitted when you use your Prepaid Benefits Card. The cards are reloaded each year and for multiple years' use.
2. **Automatic Rollover** – No Claim Submission: If you elect the auto-rollover for FSA reimbursement, unpaid amounts from the medical plan will automatically be reimbursed in the form of a check issued from your available FSA balance.
3. **Hard-Copy Claims Submission** – If you do not use the Prepaid Benefits Card and/or do not elect Automatic Rollover, you will need to submit a claim form for reimbursement from your Account. When submitting a claim, you will need the following information/documentation:
   - a reimbursement claim form, and
   - **for the Health Care FSA:** documentation from the provider of the goods or services you received (e.g., a receipted bill, an unpaid bill, a signed affidavit, or an explanation of benefits), the nature, date and amount of expense, and/or
   - **for the Dependent Care FSA:** the name, address and taxpayer identification number of the dependent care service provider. In the case of a baby sitter, the taxpayer identification number is the baby-sitter's Social Security number.

Claim forms are available from the Human Resources, Employee Health Insurance website.



Spending

If your Health Care Account claim is greater than the contribution you elected for the year, the reimbursement will be limited to your annual contribution. If your Dependent Care Account claim is greater than your contribution up to that point, you will be reimbursed up to the accrued contribution, and additional reimbursement checks will automatically be issued as future contributions are made.

IMPORTANT IRS Rules

By allowing you to contribute to the spending accounts on a before-tax basis (meaning that you pay no federal income or Social Security taxes, and in most cases no state taxes on your contributions), the Internal Revenue Service (IRS) has established the following:

You now have the option to carryover up to $500 of your Flexible Spending funds into the following Flexible Spending Plan Year. This eliminates the previous "Use it or Lose it" rule. These funds will be used before any new contribution funds,

No Transfers: The health care and dependent day care spending accounts must be maintained separately; money cannot be transferred from one account to the other.

Flexible Spending Accounts (continued)

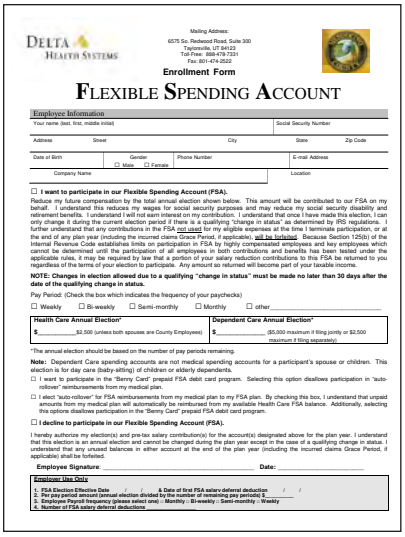
The following lists are examples of what medical expenses can/cannot be paid from your Flexible Spending Account (FSA). For a complete list and detailed definitions, refer to IRS Publication 502.

Qualified Medical Expenses

- Ambulance
- Bandages
- Birth Control
- Chiropractor
- Contact Lenses
- Dental Treatment
- Eye Glasses
- Hearing Aids
- Hospital Services
- Laboratory Fees
- Lodging/Meals
  (essential to medical care;
  not a part of inpatient care)
- Operation/Surgery
- Over-the-Counter Medicines
  (only when prescribed by a physician)
- Stop-Smoking Programs
- Transportation
  (essential to medical care)
- Wig
- X-ray

Non-Qualified Medical Expenses

- Childcare
- Cosmetic Surgery
- Electrolysis or Hair Removal
- Flexible Spending Account
- Funeral Expenses
- Future Medical Care
- Health Club Dues
- Household Help
- Nutritional Supplements
- Over-the-Counter Drugs and Medicines without a prescription from a physician (except insulin)
- Teeth Whitening



DELTA HEALTH SYSTEMS

Mailing Address:
6575 So. Redwood Road, Suite 300
Taylorsville, UT 84123
Toll-Free: 888-478-7331
Fax: 801-474-2522

Enrollment Form

FLEXIBLE SPENDING ACCOUNT

Employee Information

Your name (last, first, middle initial) | Social Security Number

Address | Street | City | State | Zip Code

Date of Birth | Gender ☐ Male ☐ Female | Phone Number | E-mail Address

Company Name | Location

☐ **I want to participate in our Flexible Spending Account (FSA).**

Reduce my future compensation by the total annual election shown below. This amount will be contributed to our FSA on my behalf. I understand this reduces my wages for social security purposes and may reduce my social security disability and retirement benefits. I understand I will not earn interest on my contribution. I understand that once I have made this election, I can only change it during the current election period if there is a qualifying "change in status" as determined by IRS regulations. I further understand that any contributions in the FSA not used for my eligible expenses at the time I terminate participation, or at the end of any plan year (including the incurred claims Grace Period, if applicable), will be forfeited. Because Section 125(b) of the Internal Revenue Code establishes limits on participation in FSA by highly compensated employees and key employees which cannot be determined until the participation of all employees in both contributions and benefits has been tested under the applicable rules, it may be required by law that a portion of your salary reduction contributions to this FSA be returned to you regardless of the terms of your election to participate. Any amount so returned will become part of your taxable income.

NOTE: Changes in election allowed due to a qualifying "change in status" must be made no later than 30 days after the date of the qualifying change in status.

Pay Period: (Check the box which indicates the frequency of your paychecks)

☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly ☐ other_____

Health Care Annual Election*	Dependent Care Annual Election*
$_____ $2,500 (unless both spouses are County Employees)	$_____ ($5,000 maximum if filing jointly or $2,500 maximum if filing separately)

*The annual election should be based on the number of pay periods remaining.

Note: Dependent Care spending accounts are not medical spending accounts for a participant's spouse or children. This election is for day care (baby-sitting) of children or elderly dependents.

☐ I want to participate in the "Benny Card" prepaid FSA debit card program. Selecting this option disallows participation in "auto-rollover" reimbursements from my medical plan.

☐ I elect "auto-rollover" for FSA reimbursements from my medical plan to my FSA plan. By checking this box, I understand that unpaid amounts from my medical plan will automatically be reimbursed from my available Health Care FSA balance. Additionally, selecting this options disallows participation in the "Benny Card" prepaid FSA debit card program.

☐ **I decline to participate in our Flexible Spending Account (FSA).**

I hereby authorize my election(s) and pre-tax salary contribution(s) for the account(s) designated above for the plan year. I understand that this election is an annual election and cannot be changed during the plan year except in the case of a qualifying change in status. I understand that any unused balances in either account at the end of the plan year (including the incurred claims Grace Period, if applicable) shall be forfeited.

Employee Signature: _____ **Date:** _____

Employer Use Only

1. **FSA Election Effective Date** ___/___/___ **& Date of first FSA salary deferral deduction** ___/___/___
2. **Per pay period amount (annual election divided by the number of remaining pay periods) $**_____
3. **Employee Payroll frequency (please select one): ☐ Monthly ☐ Bi-weekly ☐ Semi-monthly ☐ Weekly**
4. **Number of FSA salary deferral deductions** _____

Salary Reduction Agreement

If you choose to take advantage of the Flexible Spending Account program these forms must be completed each year during the open enrollment period.

Employee Wellness Program

Mendocino County Working on Wellness (MCWOW) Program

The County of Mendocino offers to all employees (and their dependents over age 18 covered on the County health plan) a free, voluntary Wellness program focused on the enhancement of individual health both at work and at home. The basic goals of the wellness program are:

- Enhancement of employee or dependent health, safety and morale
- Reduction in the incidence of lifestyle related illness and disease among county employees and their families
- Development of healthier work environments that encourage and support employees and dependents to adopt and maintain healthier lifestyles
- Reduction of County costs for medical care for employees/dependents and a reduction in the cost of individual employee personal medical care expenses.

Wellness Incentive Program

To promote the health and well being of County employees, the County has partnered with HealthFitness™ to provide a Wellness Incentive program. The Incentive program is designed to motivate and encourage employees covered on the County Health Plan to engage in wellness activities such as onsite Biometric Health Screenings, personal Health Risk Assessments, telephonic health coaching, online health education courses and various MCWOW activities such as on-site health education classes and annual County-wide Health Challenge Campaigns. All services are confidential and private.

The Wellness Incentive Program allows employees on the County Health Plan to earn up to $500 off their annual Health Plan premiums (or deductible) when they complete specified criteria outlined below. A new Incentive Program begins each January with incentive rewards effective the following calendar year.

Incentive Program Requirements:

Earn 1,000 Wellness Points between Jan 1 – Nov 1.

- **Biometric Health Screening:** 450 points
- **Health Assessment Questionnaire:** 450 points
- **Health Coaching/Advising:** 25 points per session
- **Wellness Challenges:** 40 points per challenge
- **Preventive Screening:** 30 Points
- **Onsite Classes/Online Webinars:** 10 points each
- **Physical Activity:** 5 Points per hour.

For additional information about the MCWOW program, please contact the Human Resources/Benefits Office, Mendocino County Working on Wellness (MCWOW) program at 707.234.6610. Additional details can be found by visiting www.mendocinocounty.org/hr/mcwow.

working on wellness mendocino county

Employee Assistance Program

The County provides an Employee Assistance Program (EAP), which is administered by Magellan Health Services of California (Magellan). Magellan provides confidential, professional short-term counseling services for you and members of your household. The EAP also provides online services for County employees.

Eligibility

All employees and members of their household can receive assistance and counseling through Magellan regardless of coverage under the County health plan.

Access

Call Magellan directly at 800.424.4039 to make an appointment. This number is available 24 hours a day, 7 days a week. All services are completely confidential and private. TDD callers dial 800.635.2883.

You can access Magellan's online EAP Services at www.mendocinocounty.org/hr/eap

EAP Benefits

The program provides the following, at no cost to you (no copay, coinsurance, or deductible):

- Face-to-face and telephone counseling for marital/family concerns, alcohol/drug dependency, relationships, emotional problems, stress, and other issues. Counselors are available via telephone 24/7 for urgent situations. Employees and all household members are covered.
- **Legal matters:** advice for family law, consumer issues, landlord/tenant disputes, personal injury, contracts, and criminal matters.
- **Financial:** budgeting, credit issues, and financial planning.
- **Daily living services including:**
  - Help locating services and information about home improvement, automotive, pet care, cleaning, relocation, travel, etc.
  - Child and elder care assistance. Assessing needs, choosing resources, and exploring payment options. Assistance with schools, parenting, adoption, pregnancy, education, senior services, Medicare, retirement, hospice and aging well.

Note: All employees receive six (6) counseling sessions per issue per 12-month period for themselves and each covered dependent. Members of the DSA/MCLEMA Bargaining Unit receive ten (10) counseling sessions per issue per 12-month period.

Important Notices

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for pregnancy hospital stay (for delivery) for a mother and her newborn generally may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA) Annual Notice

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 707.234.6600 for more information.

Patient Protections

The medical plan requires 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. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact your carrier.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the plan 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, please contact your carrier.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Anthem Blue Cross. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims, and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified

Important Notices (continued)

Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or,
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- The parent-employee dies;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or,
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. The employer must notify the Plan Administrator of the following Qualifying Events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or,
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if part of the employer's plan), are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, no later than the date specified in the election form, and properly addressed to the Plan Administrator.

Each notice must include all of the following items: the covered employee's full name, address, phone number and Social Security Number; the full name, address, phone number and Social Security Number of each affected dependent, as well as the dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the employer or Plan Administrator.

Important Notices (continued)

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their dependent children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation of coverage, for a maximum of 36 months, if the Plan is properly notified about the second Qualifying Event. This extension may be available to the spouse and any dependent children receiving COBRA continuation of coverage if the employee or former employee dies; becomes entitled to Medicare (Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second Qualifying Event would have caused the spouse or the dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

IF YOU HAVE QUESTIONS

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans subject to ERISA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

For more information about the Marketplace, visit www.healthcare.gov.

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), has jurisdiction with respect to the COBRA continuation coverage requirements of the Public Health Service Act (PHSA) that apply to state and local government employers, including counties, municipalities, public school districts, and the group health plans that they sponsor (Public Sector COBRA). COBRA can be a daunting and complex area of federal law. If you have any questions or issues regarding Public Sector COBRA, you may contact the Plan Administrator or email HHS at phig@cms.hhs.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

Important Notices (continued)

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for non-COBRA beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or the Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and / or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and / or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination for eligibility for such assistance.

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death or Qualified Medical Child Support Order, you may be able to enroll yourself and / or your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption or placement for adoption or divorce (including legal separation and annulment).

For information about Special Enrollment Rights, please contact:

Health Benefits Administration
707.234.6600

Important Notices (continued)

Medicare Part D – Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the County of Mendocino 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:

- **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.**
- **The County of Mendocino has determined that the prescription drug coverage offered by the County of Mendocino Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current County of Mendocino coverage will not be affected. If you keep this coverage and elect Medicare, the County of Mendocino coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current County of Mendocino coverage, be aware that you and your dependents will 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 the County of Mendocino 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 (i.e., a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed below for further information. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the County of Mendocino changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

Important Notices (continued)

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

- 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 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 www.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, 2019
Name of Entity / Sender:	County of Mendocino
Contact:	Human Resources Department
Address:	501 Low Gap Road, Room 1326 Ukiah, CA 95482
Phone:	707.234.6600

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

The County of Mendocino Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact

County of Mendocino
Human Resources Department
501 Low Gap Road, Room 1326
Ukiah, CA 95482
707.234.6600

Or download the notice from the County website:
www.mendocinocounty.org/hr/ehb

Important Notices (continued)

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about the County of Mendocino in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855.653.3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through Covered California begins October 15, 2018 and ends on January 15, 2019. Open Enrollment for most other states will close on December 15, 2018.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.56% (for 2018) and 9.86% (for 2019) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's medical plan.

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

PART B: EXCHANGE APPLICATION INFORMATION

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855.653.3626 or at www.KeenanDirect.com.

3. Employer name County of Mendocino	**4. Employer Identification Number (EIN)** 94-6000520	
5. Employer address 501 Low Gap Road, Room 1326	**6. Employer phone number** 707.234.6600	
7. City Ukiah	**8. State** CA	**9. ZIP code** 94582
10. Who can we contact about employee health coverage at this job? Health Benefits Administration		
11. Phone number (if different from above)	**12. Email address** hr@mendocinocounty.org	

Important Notices (continued)

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 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 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, 2018. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 855.692.5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 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: 855.MyARHIPP (855.692.7447)

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:
800.221.3943/ State Relay 711
CHP+: https://colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 800.359.1991/ State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 877.357.3268

GEORGIA – Medicaid
Website: http://dch.georgia.gov/medicaid
Click on Health Insurance Premium Payment (HIPP)
Phone: 404.656.4507

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877.438.4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 800.403.0864

IOWA – Medicaid
Website:
http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 888.346.9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 785.296.3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/agencies/dms
Phone: 800.635.2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 888.695.2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 800.442.6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 800.862.4840

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp | Phone: 800.657.3739

MISSOURI – Medicaid
Website:
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573.751.2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800.694.3084

Important Notices (continued)

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855.632.7633
Lincoln: 402.473.7000
Omaha: 402.595.1178

NEVADA – Medicaid
Medicaid Website: https://dwss.nv.gov/
Medicaid Phone: 800.992.0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603.271.5218
NH Medicaid Service Center Hotline: 888.901.4999

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: 800.701.0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 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: 844.854.4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888.365.3742

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 800.699.9075

PENNSYLVANIA – Medicaid
Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 800.692.7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855.697.4347

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 888.549.0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 888.828.0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 800.440.0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877.543.7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800.250.8427

VIRGINIA – Medicaid and CHIP
Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 800.432.5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 855.242.8282

WASHINGTON – Medicaid
Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 800.562.3022 ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 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, 2018, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

Contact Information

Below is a listing of the toll-free numbers you can call with questions about the plans available to you. You can also use the website (if available) to access information from providers for the various plans.

Benefit Offered	Phone	Contact Information/Website
Medical		
• Claims	800.291.0726	Send claims to Anthem Blue Cross PO Box 60007 Los Angeles, CA 90060-0007 www.anthem.com/ca
• PlushCare	866.460.6205	www.plushcare.com
• Pre-Authorization	800.274.7767	
• Coverage while Traveling	800.810.BLUE	
Pharmacy		
• Express Scripts	800.711.0917	
Dental/Vision		
• Delta Dental	800.765.6003	Send claims to Delta Dental PO Box 997330 Sacramento, CA 95899-7330 www.deltadentalins.com
• Vision Service Provider (VSP)	800.877.7195	Send claims to VSP PO Box 385018 Birmingham, AL 35238-0518 www.vsp.com
Flexible Spending Accounts		
• Claims/General Information	888.478.7331	Send claims to Delta Health Systems 6675 S. Redwood Road, Suite 300 Taylorsville, UT 84123 www.deltahealthsystems.com
Employee Wellness Program		
• MCWOW	707.234.6610	www.mendocinocounty.org/hr/mcwow
• HealthFitness™	800.337.8508	www.mcwow.biovia.healthfitness.com
Employee Assistance Program		
• Magellan Health	800.424.4039	www.magellanassist.com
Voluntary Benefits		
• Aflac	Jason Shepherd, 707.462.4169	www.aflac.com
• CalPERS - 457 Plan	David Vallerga, 888.713.8244, ext. 6	http://calpers.voya.com/eportal/welcome.do
• CalPERS - LTC	800.908.9119	www.CalPERSLongTermCare.com
• CalStar & REACH Air Ambulance	800.793.0010	www.airmedcarenetwork.com
• Mutual of Omaha	800.775.8805	Jenny.Wong@LibertyMutual.com
• Liberty Mutual	Kate Fuhrman, 925.658.1997	Kate.Fuhrman@LibertyMutual.com
• MassMutual	Kerry Avila, 707.822.1328	dvallerga@massmutual.com
• MERP J&K Consultants	877.872.423	
Human Resources Benefit Specialists	707.234.6604	www.mendocinocounty.org/hr/ehb

Website Walk-through

County of Mendocino Health Benefits Website

You may access the Health Benefits website by going to www.mendocinocounty.org/hr/ehb. The following information provides a quick overview of each section of the website and where you can go to access important information about your health benefits options.

Health Plan Summary

- General overview of Plan Coverages and Health Care Reform Updates/Notices
- County Summary Plan Description (or SPD) which provides detailed eligibility and plan coverage information
- Plan Summary Comparison which provides a brief summary and side by side comparison
- Plan Summary and Rates

Medical Coverage - Delta Health Systems

- Delta Health Systems website link
- Anthem Network Preferred Provider link
- Toll free number for the 24-hour Nurseline
- PlushCare Information Links

Prescription Coverage

- Express Scripts website link
- Downloadable website instruction tutorial
- List of preferred and excluded medications

Vision & Dental Coverage

- Benefit summaries
- VSP website link
- Delta Dental website link
- Contact information

Health Plan Enrollment

- Qualifying Event Frequently Asked Questions for changes to coverage
- Annual Open Enrollment information

Voluntary Benefits and Discounts

- County of Mendocino Voluntary Benefits offered through Mutual of Omaha, AFLAC, Liberty Mutual, CalStar, Reach, CalPERS, MassMutual and MERP.

Flexible Spending (FSA) - Medical and Dependent Care

- Flexible Spending Program Booklet
- FSA Contacts Flyer
- FSA Eligible and Ineligible expenses
- IRS FSA Eligible Expenses website link

What's New

- Updates and Announcements

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