CITY OF FORT BRAGG

YOUR 2023-24 BENEFITS OPEN ENROLLMENT

It's time!

Open Enrollment

Each year your group health plan holds a benefits Open Enrollment. This is the time of year when we communicate benefit and rate changes that may affect you at renewal on July 1st. It's also the time of year when you can make plan changes, add coverage or add dependents.

Your elections will remain in effect through the Plan Year (July 1, 2023 through June 30, 2024) unless you make changes as a result of a Qualifying Event. (For more information on Qualifying Events, see page 3 or contact your Human Resources Department.

Review Your Benefits

Please take the time to review the information in this pamphlet so that you are fully informed of the benefits offered to you. More detailed information is available from the Human Resources Department.

Important Information

- Changes to your Health Plan premium contributions will be communicated through your Human Resources Department.
- *If you're not making any changes to your MEDICAL, DENTAL or VISION plan*, you don't have to do anything. Your current benefit election will automatically be continued as of July 1, 2023.
- *If you are participating in a Flexible Spending Account (FSA) you will need to* make a new election for the coming year. Please contact your Human Resources Department for instructions.

Important Dates

- Open Enrollment is from May 23rd to June 12th
- The deadline to make changes is June 12th

Life changes can affect the benefits you need from year to year.

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Now is the time to review what you have and make the most of your elections for the coming year
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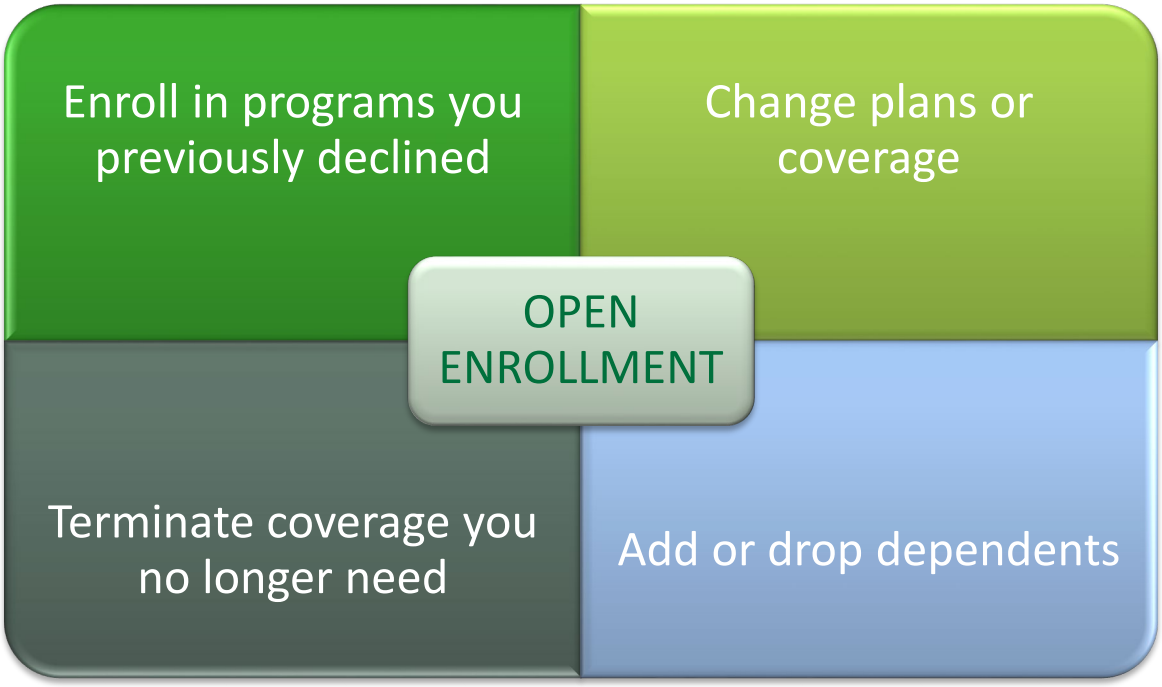
Open Enrollment

This is an official Open Enrollment period for your group insurance program for medical, dental and vision coverage. This is the time of year that you will choose your benefit elections for the next Plan Year starting July 1, 2023.

If offered, it is also time to elect to participate in your employer's Flexible Spending Account for next year. Coverage is available to eligible employees and dependents.

Open Enrollment is your time to:



All changes and additions will be effective July 1, 2023.

If you don't make changes during this Open Enrollment period, you will not be able to do so until the next Open Enrollment unless you experience a qualifying event. Qualifying events may trigger Special enrollment rights during the year. See additional information on Special Enrollment Rights, below.

Preparing for Open Enrollment – thoughts to consider

- ✓ What changes have occurred for you in the last year? These could include life events (marriage, birth, divorce, etc.), health changes, income changes, etc.
- ✓ How will your changes affect your benefits for the coming year?
- ✓ Will you have new changes in the next year? (For example a move, job change, or new dependent.)
- ✓ Might you need additional benefits to cover surgery, new medical treatment or medication?

Eligibility & Enrollment

Eligibility

Active employees are eligible for benefits if they qualify under the employer's personnel policies and/or MOU. Generally, permanent full time employees (working 30+ hours per week) are eligible for coverage. In addition, part time or temporary employees may be eligible for benefits. Please check with your Human Resources Department for more detailed information.

Eligible dependents include the employee's spouse or state registered domestic partner, and children under age 26. Eligible children include biological and adopted children, stepchildren, the children of an eligible domestic partner, and children ordered to be covered through a qualified medical support order.

You are responsible for terminating dependents who are no longer eligible for coverage. Failure to notify your employer of changes in dependent eligibility may result in forfeiture of COBRA rights.

At any time, the Plan may require proof that a Spouse, Domestic Partner or a Child qualifies or continues to qualify as a Dependent as defined by the Plan.

For complete definitions of eligible persons, please see the Summary Plan Description available from your Human Resources Department.

Enrollment

Enrollment takes place in one of three enrollment periods:

- Initial Eligibility Period – this period is based on the hire date and your employer's waiting period. Each newly hired or newly eligible employee is given the opportunity to enroll once they become eligible for benefits.
- Open Enrollment Period – The annual period during which eligible employees may make or change new benefit elections. Changes take effect on the first day of the new Plan Year.
- Special Enrollment Period – a period that occurs following a qualifying life event, as defined under federal law (HIPAA) provisions.

Special Enrollment Rights

Federal law (HIPAA) provides Special Enrollment provisions under some circumstances. If you previously declined coverage for yourself or an eligible dependent, you may have a Special Enrollment Right to enroll in this plan if you experience a qualified life event.

Qualifying events may include, but are not limited to:

- A loss of other coverage due to:
  - A loss of eligibility due to:
    - Termination of employment, change in employment status, reduction of hours, employer termination of the plan or benefits class
    - Ineligibility due to divorce or legal separation, termination of domestic partnership or cessation of dependent status (e.g. aging off of a parent's plan at age 26)
    - Termination of group benefits under another employer health plan at that

employer's Open Enrollment
    - A loss/gain of eligibility due to a change in employment status for you or your spouse/domestic partner (commencement, termination, leave of absence, full-time to part-time or vice versa)
- Exhaustion of COBRA benefits
- Acquiring a newly eligible dependent through birth, adoption, placement for adoption, marriage, registered domestic partnership, or court order for child coverage
- Losing or gaining eligibility for Medi-Cal or State Child Health Insurance Programs

Making Changes after a Qualifying Event

Generally, changes in your coverage elections must be made within 31 days of the qualifying event. You are responsible for notifying the Human Resources Department of any qualifying event and for requesting information on changing your elections. For further information on eligible qualifying events, please contact the Human Resources Department.

How to Enroll/Make Changes

To enroll or make changes to your plans or dependent eligibility, obtain an enrollment/change form from your Human Resources Department, or use the HealthComp Online link provided by your HR Representative. Your Human Resources Department can provide access to all forms and documents you will need for enrollment or changes.

If your employer utilizes the HealthComp Online portal, you will be able to make changes online and submit electronically.

What Happens After Enrollment

When your enrollment is submitted, your HR Department will review your submission and reach out to you for any missing information or documentation (e.g. proof of loss of coverage, marriage or birth certificate, etc.) Once approved, your enrollment will be processed and new ID cards will be generated and sent to you. (No ID cards are issued for VSP, Delta or life and disability.) Once received, please review your cards and keep them safely stored. If any information is incorrect, please notify your Human Resources Department.

What Happens if you Don't Enroll

An employee who does not enroll during the Initial Enrollment period will be able to enroll at Open Enrollment, or within 31 days after experiencing a Qualifying Event. An employee who does not enroll or make elections during Open Enrollment will be unable to make changes until the next Open Enrollment unless he/she experiences a Qualifying Event.

Terminating Employment

If your employment terminates your benefits will end. Benefits end on the last day of the calendar month of employment. You may have the right to continue coverage for yourself and any covered dependents under COBRA.

When employment ends, you will be eligible to convert life insurance coverage (and LTD coverage, if applicable) to an individual policy. For information on Life Conversion and LTD Conversion, contact your Human Resources Department.

MEDICAL COVERAGE

The summaries provided here contain highlights only. The specific terms of coverage, exclusions and limitations are contained in the Plan Documents and insurance certificates. All coverages and the costs for such coverage for all participants are subject to change at any time in the future. If you have questions about a specific service or treatment, please contact your Human Resources Department or our broker, RealCare at (707) 939-8088.

REMIF Self-Funded Medical Plan

There are mandatory changes to deductibles for REMIF High Deductible Health Plans (HSA) for 2023/24. There are no changes to copays, or out of pocket costs for the REMIF Plans for next year. Below is a brief summary of the REMIF medical benefits. For more detailed information, please pick up a Benefit Summary form or request a copy of the Summary Plan Description from your Human Resources Department.

Benefits	EPO 250 In Network Only	EPO 500 In Network Only	HSA 1500 In Network	 Out of Network
Plan Year Deductible	$250 Single $500 Two Party $750 Family	$500 Single $1,000 Two Party $1,500 Family	**$1,500 Single $3,000 Family of 2 or more**	
Plan Year Out of Pocket Max (OOP) [1]	**Total Out of Pocket Maximums** $5,000 Single $10,000 Two Party $13,200 Family ***Separate Medical and Rx OOP maximums accumulate per person up to the family maximum***		$5,000 Single $10,000 Family of 2 or more **(OOP maximum for Medical/Rx are combined)**	
	Benefits below are what the MEMBER PAYS <u>after deductible</u> unless noted			
Physician Visits				
Primary Care	$25 Copay Ded. Waived	$30 Copay Ded. Waived	10% after deductible	30% after deductible
Specialists	$35 Copay Ded. Waived	$40 Copay Ded. Waived	10% after deductible	30% after deductible
LiveHealth Online	$10 Copay; Ded. Waived	$10 Copay; Ded. Waived	10% after deductible	N/A
Emergency Care	$150 Copay Wvd if Admitted	$150 Copay + 10% Wvd if Admitted	10% after deductible	
Rx Benefits Retail: 30 days **Retail Maintenance & Mail Order (MO): 90 day**	Not subject to deductible	Not subject to deductible	**Copays apply <u>AFTER</u> deductible**	
Tier 1 - Generic	$10 Copay Retail $15 Copay Retail Maint. or MO	$15 Copay Retail $23 Copay Retail Maint. or MO	$10 Copay Retail $20 Copay Retail Maint. or MO	Member pays applicable Copay plus all charges in excess of allowable charge
Tier 2 - Preferred Brand	$25 Copay Retail $38 Copay Retail Maint. or MO	$35 Copay Retail $53 Copay Retail Maint. or MO	$25 Copay Retail $50 Copay Retail Maint. or MO	
Tier 3 - Non-Preferred Brand	$50 Copay Retail $75 Copay Retail Maint. or MO	$50 Copay Retail $75 Copay Retail Maint. or MO	$50 Copay Retail $100 Copay Retail Maint. or MO	
Tier 4 - Specialty	$150 Copay	$150 Copay	20% of max. allowed amount	
Specialty (30 day supp) Must obtain from Specialty Pharmacy	Member pays applicable cost for tier	Member pays applicable cost for tier	Member pays applicable cost for tier	Not Covered

1) The Out of Pocket Maximums for Rx and Medical accumulate separately on a per person basis on all plans EXCEPT the HSA 1500. The combined out of pocket maximum will not exceed the total OOP maximum shown for all plans.

REMIF Pharmacy Benefits

Your REMIF medical plan includes prescription drug coverage through Express Scripts (ESI). ESI provides benefits for retail, mail order, and Specialty medications; as well as a number of clinical programs to help patients manage medications.

In Network Pharmacies

ESI uses all major chain pharmacies and many small independent pharmacies. The major chains include: CVS, Rite Aid, Walgreens, Pharmaca, Lucky, Raley's, Costco, Safeway, and Walmart.

Formulary

A formulary is a list of preferred and non-preferred drugs available to members. The formulary is updated periodically to review drugs for their safety, clinical efficacy, cost, and therapeutic need. When the formulary list changes, ESI will notify you if your medication status changes. A formulary status change can affect your copay, authorizations or the availability of your prescription medication.

Prior Authorizations, Quantity Limits, Step Therapy

The prescription drug program utilizes Prior Authorizations, Quantity Limits and Step Therapy to help control costs.

Prior Authorizations can be approved for specific medications, specific quantities of a medication or authorizations after completing Step Therapy requirements to try lower cost, or lower risk medications. Keep in mind that most Prior Authorizations must be renewed at least annually and sometimes more often. If your authorization ends your doctor will need to request a new authorization through ESI. If you encounter any problems, call ESI Member Services at (877) 813-2493 or contact RealCare at (707) 939-8088 for assistance.

Specialty Medications

Specialty medications are used to treat complex conditions. Some need to be administered by injection or infusion and require special handling or refrigeration, while others are oral or inhaled medications. All Specialty Medications must be obtained through a mail order pharmacy. *ESI's specialty pharmacy is Accredo.*

EXPRESS SCRIPTS®

IMPORTANT RX INFORMATION

- How do I set up Mail Order medications? You can set up mail order prescriptions online at express-scripts.com. There you can register or log in to your account and transfer your existing prescriptions to ESI for mail order delivery. If you have a new medication to set up, call Customer Service and they'll confirm your new medication with your doctor and set up mail order.
- What if my drug is not on the formulary list? Notify your doctor that your drug is no longer on the formulary. Your doctor will be able to access the ESI formulary list and recommend an alternative medication for you. If your doctor determines that you cannot take alternative medication due to medical necessity, he or she can request an authorization for you to continue to use your current medication.
- Who should I call for help? Contact the ESI Member Services Department at (877) 813-2493 or contact RealCare at (707) 939-8088 for assistance.

Additional REMIF Health Plan Benefits

LiveHealth Online – A convenient way to "see" a doctor!

Every REMIF Self-Funded medical plan features access to LiveHealth Online - an Anthem Blue Cross service that gives you access to a doctor 24 hours a day, 7 days a week. LiveHealth Online is quick and easy. Doctors using LiveHealth Online can answer your questions, assess your condition and even provide prescriptions* if needed.

Most members will pay a $10 Copay for general physician or mental health services. Members on an HSA Compatible plan will be required to pay the full cost of the doctor visit (usually $59 for a general practitioner or $95-$175 for a mental health provider) which will be applied to the deductible. All payments are counted toward the member's out of pocket maximum. Sign up online at www.Livehealthonline.com.

**Prescription availability is defined by physician judgment and state regulations.*

AirMedCare Network Air Ambulance

AMCN Includes: REACH, CalStar, Cal-Ore and many other affiliates

Membership applies to eligible REMIF Self-Funded Medical Plan Participants Only – HSA Plan Participants are excluded from this coverage

Air ambulance claims can cost between $40,000 and $90,000 or more. The REMIF health plan covers air ambulance services regardless of AMCN membership, but without membership, participants could still pay a deductible and out of pocket costs. To help offset the cost of claims and protect participants from the risk of out of pocket expenses, REMIF partnered with AMCN to purchase membership for all eligible REMIF Medical Plan participants.

REMIF Medical Plan members not eligible for AMCN membership are those living outside of an AMCN service area and those covered on an HSA plan. Remember, your AMCN membership covers you, your dependents on the plan, and all household members whether they're on a health plan or not.

Care Advocate Program

The diagnosis and management of a serious medical condition can be confusing and lead to emotional stress and financial worry. The HealthComp Care Advocate Program provides assistance to individuals and their families dealing with a complex health condition. HealthComp's Case Managers help you understand your benefits and work with your doctors to coordinate care. This program is completely free, voluntary, and confidential.

Want more information? Call HealthComp at (800) 755-7247 6:00 AM to 4:30 PM.

EAP

Your Employee Assistance Program

Aetna Resources For Living

REMIF contracts with Aetna for EAP services which provide up to 8 face to face counseling sessions per member per incident. In addition, Aetna provides many other services to members.

This program is no cost to you, and is available to all members of your household, including dependent children over 26. Services are confidential and available 7 days a week.

- Personalized guidance and help finding resources for
  - Child care & summer programs
  - Elder care
  - Caregiver support
  - Pet care
  - Home repair & services
- Online resources for
  - Wellness, nutrition and fitness
  - Stress management
  - Discounts on name brand products and services
- Legal services
  - Free 30 minute consultation with an attorney
  - Assistance with wills
- Financial consultations for
  - Budgeting
  - Credit and debt issues
  - College funding
  - Taxes
  - Retirement & financial planning

Aetna (800) 342-8111▪ www.resourcesforliving.com ▪ User: REMIF ▪ PW: eap

Globally, over **264 million** adults suffer from anxiety and stress each day and over **280 million** battle depression.[1]

There are ways to improve your mental health and wellbeing. Beginning with how we handle every day tasks and encounters with others can help to make a difference.

Ways you can start to improve your mental health and wellbeing

Combat stress with simple tricks like this:

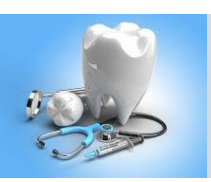
- Replace phrases in your every day self-talk from, "have to" and "can't" into "choose to" and "choose not to". This will remind you that there is a choice. Your body responds differently when it does not feel stuck.
- Practice self-compassion, which is treating yourself as kindly as you would a good friend.

Research shows that people who are self-compassionate are less likely to be depressed, anxious and stressed.

Self-compassion and the words we choose can increase our overall wellbeing

Finding an outlet can cut down on negative emotions and help alleviate stress

- Regular exercise can lift emotions
- Meditation helps to provide an inner space of peace
- Opportunities for fun and laughter help combat stress



Dental Benefits

DELTA DENTAL®

There are no benefit changes for Delta Dental for 2023/24. Remember, starting last year, your maximum benefit increased *and* your Diagnostic and Preventive Care services does *not count* toward your maximum benefit.

Your Delta Dental plan saves you money on dental services. REMIF partners with Delta Dental to give members access to the largest dental provider networks available. Chances are your dentist participates with Delta Dental – either as a PPO provider or a Premier network dentist. But, if you want to use an out of network dentist, you can do that too! Below are important highlights of the plan and a brief overview of your benefits.

Plan Highlights

- No Deductible
- No waiting periods
- Orthodontia for adults and children
- $1,800 Plan Year maximum benefit
- Diagnostic & Preventive Care don't count toward your maximum annual benefit

Benefit Overview

Covered Service	Plan Pays	
	Delta Dental PPO Dentist	Delta Premier or Out of Network Dentist
Diagnostic & Preventive Care *(does not count toward maximum benefit)* • Exams, cleanings, X-rays	100%	100%
Basic Services • Fillings, simple extractions • Endodontics (root canals) • Periodontics (gum treatment) • Oral Surgery • Crowns, inlays, onlays, cast restorations	85%	80%
Major Services • Bridges and dentures	50%	50%
Orthodontic Benefits • Adults and dependent children	50% to lifetime maximum benefit per person of $1,000	50% to lifetime maximum benefit per person of $1,000
TMJ Benefits	50% to lifetime maximum benefit per person of $300	50% to lifetime maximum benefit per person of $300

Don't forget…

- ✓ Your FREE diagnostic and preventive care is important to your health
- ✓ Your benefit year starts on July 1st
- ✓ You save $$$ with Delta Dental PPO *and* Premier Dentists

Vision Benefits

There are no benefit changes for VSP for 2023/24.

REMIF's VSP program covers your annual WellVision exam, and will help pay for eyeglasses or contacts. While you can use any provider for vision services, you will get the best value when using a VSP Signature participating provider.

Your WellVision exam is an important part of your overall health maintenance. Your VSP Signature provider will perform a comprehensive vision exam which includes information on your family history, your medical conditions and medications, and a thorough check of your vision itself. Your exam can help your doctor see signs of common health conditions like high cholesterol, high blood pressure, glaucoma and diabetes.

Below is a brief overview of your VSP In-Network benefits. For detailed information, please refer to your Benefit Summary, or call VSP.

Benefit	Description	In-Network Copay
WellVision Exam	• Comprehensive vision exam • Every 12 months	$0
Prescription Glasses & Services		
Frames	• $200 frame allowance • $220 frame allowance for featured brands • 20% savings on amounts over the allowance • Every 24 months	$0
Lenses	• Single vision, lined bifocal or trifocal • Polycarbonate lenses for dependent children • Every 12 months	$0
Contacts (instead of glasses)	• $140 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease • Retinal screening for eligible members • Limitations may apply • Provided as needed	$20
Extra Savings	• Extra Glasses & Sunglasses – extra $20 to spend on featured brands • 30% savings on additional glasses and sunglasses from same VSP provider on same day as your exam or 20% off from any VSP provider within 12 months of your last exam • Retinal Screening – no more than a $39 copay on routine retinal screening as an enhancement to your WellVision exam • Average 15% off regular price or 5% off promotional price for Laser Vision Correction from contracted facilities	

Life & Disability Benefits

Life and AD&D Benefits

Basic Life and AD&D

The City provides Group Life and Accidental Death & Dismemberment (AD&D) benefits through Lincoln Financial. Basic coverage is paid by the City and coverage amounts vary depending on your bargaining unit agreement.

If you die while actively employed by the City, your policy will pay a cash benefit to your designated beneficiaries. If you are diagnosed with a terminal illness you also have the option to apply for an accelerated death benefit.

If your death is the result of an accident, the AD&D policy will pay a benefit that will normally match your basic life benefit. The AD&D benefit also pays for certain accidental injuries such as the loss of a limb or eyesight.

Beneficiaries

When you enroll in basic life and AD&D insurance you will designate a beneficiary (or beneficiaries) for your policy. You can designate anyone as your beneficiary and may change beneficiaries at any time by completing a new beneficiary form and submitting it to your Human Resources Department. If you are married and do not designate your spouse as at least 50% beneficiary, your spouse must sign a form acknowledging they will not be receiving at least 50% of the life insurance benefit. It is important to review and update your beneficiary designations periodically to ensure they reflect your current wishes.

Portability

In the event that you terminate employment, you may convert (or "port") your life insurance to individual coverage. To do so you must apply for conversion within 30 days of termination of employment. Contact your Human Resources Department for information on portability.

Additional Benefits from Lincoln Financial

Online Will Preparation

Having a will allows you to designate who will receive your property and assets when you're gone. Without one, your state determines how your estate is distributed. Online will preparation services are available with LifeKeys® services, which is included with your life insurance policy from Lincoln Financial Group. EstateGuidance® will preparation is a quick and easy way to create and execute a will.

Visit https://www.estateguidance.com/ to get started. Enter "Lifekeys" in the Promotional Code to receive discounted products.

TravelConnect®

Lincoln TravelConnect® helps protect you and your family when you travel. In an emergency, Lincoln will help with travel arrangements, evacuation, medication delivery, recovering luggage or documents, or referrals for medical or dental care.

Disability Benefits

Long Term Disability

Long Term Disability (LTD) Insurance helps in the event that you are sick or injured and cannot work. This important coverage will help replace your income while you're disabled. Many cities pay for Long Term Disability Insurance through Lincoln Financial. Your benefit amount is determined by your bargaining unit agreement. Generally, LTD policies require that you must be disabled for a certain period of time (called an "Elimination Period") before benefits will begin. Once you've satisfied the Elimination Period, the plan will pay a percentage of your pre-disability earnings for a specified period of time.

For detailed information on life and disability benefits, please contact your Human Resources Department.

Disability affects more than 5% of Americans each year. A disability that keeps you from working can happen at any time, and will affect your health and wellbeing physically, emotionally and financially. Disability benefits help ease the financial burden by replacing a portion of your income.

Disability affects all of us. According to the latest CDC statistics, approximately 1 in 4 Americans have some type of disability.[1] Accidents account for most disability claims each year. While you can follow safety measures and generally be cautious, there are some accidents we just have no control over. However disability claims due to illnesses are sometimes preventable. Here are some keys to preventing disabling illnesses:

- Get plenty of exercise – movement helps your overall health
- Take control of your weight – obesity can lead to a number of disabling illnesses
- Eat a healthy diet – a varied diet
- Know your numbers – keeping track of your blood sugar, blood pressure, cholesterol and other factors help you manage your overall health

[1] Centers for Disease Control and Prevention. Disability and Health Data System (DHDS) [Internet]. [[updated 2022 May; cited 2022 December 12]. Available from: http://dhds.cdc.gov

A note about HSAs

What is an HSA?

The term "HSA" stands for "Health Savings Account." This is a special savings account designed to reduce your taxes and allow you to pay for qualified medical expenses on a pre-tax basis. To be eligible to contribute to an HSA you must be enrolled in a qualified High Deductible Health Plan and meet the criteria shown below.

Am I Eligible to Open a Health Savings Account?

An eligible individual is someone who:

- Is covered under a qualified HDHP on the first day of the month in which the HSA is established
- Is not covered by another health plan that reimburses you for expenses, unless it is another HDHP (exceptions exist for insurance that covers accidents, disability, dental, vision, long-term care, and other "permitted insurance")
- Is not enrolled in Medicare
- Cannot be claimed as a dependent on another person's tax return

What is a qualified High Deductible Health Plan (HDHP)?

A qualified HDHP is a High Deductible Health Plan meets federal deductible limits and does not offer first dollar medical and prescription expenses. With these plans, you will pay all covered medical and prescription expenses until you have met your deductible. The plan will begin paying benefits once the deductible is met. The only exception to this is for preventive care that meets federal guidelines.

Year	Type of Coverage	Minimum Annual Deductible	Maximum Out-of-Pocket Expenses
2023	Single / Family	$1,500/$3,000	$7,500/$15,000

Health Savings Accounts Offer Great Benefits!

- Tax Savings: An HSA provides you with triple tax savings: (1) federal tax deductions when you contribute to your account; (2) tax-free earnings through investment, and (3) tax-free withdrawals for qualified medical expenses
- Flexibility: You can use the funds to pay for current medical expenses or save the money in your account for future qualified medical or retirement health needs
- Ownership: Funds remain in the account from year to year, just like an IRA. There are no "use it or lose it" rules with HSAs
- Portability: HSAs are completely portable, meaning you can keep your HSA or move it between financial institutions, even if you change jobs, change medical coverage, become unemployed, etc.

Find out More!

Your employer may contribute to your HSA on your behalf, and/or offer you the option to deduct your contributions each pay period and deposit them automatically into an HSA account. Find out more from your Human Resources Department, or by Calling RealCare at (707) 939-8088.

Important Contacts

REMIF Medical Plan

HealthComp Member Services for: ..... (800) 442-7247

- Information on medical claims, deductibles or out of pocket maximums
- Replacement medical plan ID Cards (also available at www.hconline.healthcomp.com)
- Eligibility information
- General medical benefit questions
- Prior Authorization questions

Care Advocate Program: ..... (800) 755-7247

Anthem Blue Cross for: ..... (800) 274-7767

- Assistance with Utilization Review and Prior Authorizations
- Doctor Finder: https://www.anthem.com/ca/find-care/. Enter "HEA" in the Member ID or Prefix field; choose your criteria and search

Express Scripts Member Services for: ..... (877) 813-2493

- Questions about Rx coverage
- Assistance with prior authorizations
- Questions about Mail Order or Specialty medications
- Help in finding a pharmacy

LiveHealthOnline.com for 24/7 access to a physician for an online visit ..... (855) 603-7985

REACH/AMCN for immediate Air Ambulance Transportation..... 911 or (800) 793-0010

Dental & Vision Plans

Delta Dental Member Services for: ..... (800) 765-6003

- Information on dental claims and benefits
- Help in finding a Delta Dental provider

VSP Member Services for: ..... (800) 877-7195

- Information on vision claims and benefits
- Help in finding a VSP provider

Employee Assistance Programs

Aetna EAP for: ..... (800) 342-8111

- Counseling visits
- Resources for living

RealCare Insurance Brokers

RealCare for: ..... (707) 939-8088

- Assistance with claims issues
- Help understanding benefits or eligibility
- Qualifying event questions
- Eligibility questions

REMIF Frequently Asked Questions

How does the deductible work?

A deductible is an amount that you must pay before your Plan will start to pay. Some services are available before you pay a deductible (e.g. office visits) while others require you to pay your deductible first. You only pay one deductible per Plan Year.

When does my deductible start?

Your Plan has a "Plan Year" deductible that starts on 7/1 each year.

Does the deductible apply to lab and x-ray?

Yes, you must meet your deductible for lab and x-ray services.

How can I keep my costs lower?

Using only network providers is one way to keep your costs lower. Network providers agree to accept a discounted rate for services and will not bill you for additional charges. Other ways to keep costs down include:

- Use LiveHealth Online to access a doctor – only $10 Copay (HSA members will have to pay the full cost of the visit - toward the plan deductible.)
- Choose generic drugs whenever possible
- Visit urgent care facilities instead of emergency rooms where available
- "Shop" for services by asking providers the cost for procedures
- Talk with your doctor about the most cost effective treatment for your situation. Be an active consumer of healthcare services.

How do I look up contracted medical providers?

- Visit www.anthem.com/ca/find-care/ and click on "Use Member ID for Basic Search". Enter the first three letters from your Member ID on your ID card (HEA) in the space provided. Your three letter code brings up the correct provider directory for you to search. From there you can search for providers, hospitals and other facilities.

Are the medical plans changing?

HSA plans will have a deductible change to $1,500/$3,000 per federal guidelines. There are no changes to other health plan deductibles, copayments or out of pocket maximums.

Am I getting new ID Cards this year?

HSA plan members will get new ID cards to reflect the deductible change. If you need additional cards, you can request them online at www.Healthcomp.com or call HealthComp at (800) 442-7247.

What do I do if I have to take a specific Brand Name drug for my medical condition and only a generic is available?

If your doctor can show that it is medically necessary for you to take the Brand name version of your drug then ESI will provide authorization for you to continue to take the Brand name drug. Authorizations must be obtained at least annually, and sometimes more often, depending on the situation. Your doctor can initiate the authorization by calling ESI.

Are my prescriptions changing?

Formulary changes are made throughout the year and can affect copays. In addition, Prior Authorizations expire and need to be renewed. And, if you have dual coverage, your copay amounts may change. Call ESI to ask if you need to renew your authorization, or to check copay amounts.

Where can I find the Preferred Drug List?

Go to express-scripts.com to register as a member. You will be able to search the Express Scripts formulary. If you cannot find a specific medication, call the Express Scripts Member Services at (877) 813-2493.

2023 Required Notices

➢ HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact your Human Resources Department.

➢ Medicare Part D Notice of Creditable Coverage

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Your current plan benefits can affect your eligibility for Medicare Part D coverage. The Notice of Creditable Coverage addresses these issues. Notices are distributed annually in October and are available upon request through your Human Resources Department.

➢ Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact HealthComp Administrators at (800) 442-7247; or the Member Services number for your health plan; or RealCare Insurance Marketing at (707) 939-8088.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law.

➢ Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

➢ SBC – Summary of Benefits and Coverage

The Affordable Care Act requires your health plan to provide you with a Summary of Benefits and Coverage (SBC) outlining the benefits of all your medical plans. Your Human Resources Department will provide this informational form to you and you will be able to download it from the HealthComp website.

➢ Women's Health and Cancer Rights Act Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance outlined in your benefit summary will apply.

If you would like more information on WHCRA benefits, contact your Human Resources Department.

➢ Continued Coverage Under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your covered dependents may be able to continue your medical, EAP, dental and/or vision coverage if you lose your health care coverage as the result of certain qualifying events. Contact the Human Resources Department for more information.

➢ Notice to Employees Regarding Employer Contributions to HSAs

This notice explains how you may be eligible to receive contributions from your employer if you are covered by a High Deductible Health Plan (HDHP). Your employer provides contributions to the Health Savings Account (HSA) of each employee who is covered under the REMIF HSA plan ("eligible employee"). If you are an eligible employee, you must do the following in order to receive an employer contribution:

(1) establish an HSA account with the vendor chosen by your employer for 2023 and;

(2) notify your Human Resources Department or Benefit Administrator of your HSA account information.

If you establish your HSA on or before the last day of February in 2023 and notify your employer of your HSA account information, you will receive your HSA contributions, plus reasonable interest, for 2023 by April 15 of 2024.

If, however, you do not establish your HSA or you do not notify us of your HSA account information by the deadline, then we are not required to make any contributions to your HSA for 2023. You may notify us that you have established an HSA by sending an e-mail or a written notice to your Human Resources Contact Person. If you have any questions about this notice, you can contact your Human Resources Department.

➢ 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 premiumassistance 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 yourState 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 dependentsmight be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

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

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA-Medicaid	**MAINE-Medicaid**
A HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840

IOWA-Medicaid and CHIP (Hawki)	MINNESOTA-Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: http://www.ACCESSNebraska.ne.govPhone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA-Medicaid	**SOUTH CAROLINA-Medicaid**
Medicaid Website: http://dhcfp.nv.govMedicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493

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

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

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

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

2023 Benefits Open Enrollment

Benefits Arranged By

RealCare Insurance Marketing, An NFP Company

430 West Napa Street, Suite F

Sonoma, CA 95476

(707) 939-8088

California Insurance License # 0B23546

NFP
RealCare Insurance
Marketing, Inc.