WELLSPACE HEALTH

We see You.

2024-2025
EMPLOYEE BENEFIT GUIDE

TABLE OF CONTENTS

WELCOME

At WellSpace Health, we believe that everyone deserves to be seen, no matter who you are, where you come from, where you work or what place you call home – and this includes you. High-quality, affordable healthcare is the right of every American, and you are essential in ensuring the communities in which WellSpace Health serves have the 'blanket of care' everyone deserves. We are so proud of all of our colleagues.

As a member of these communities, and of the WellSpace Health family, we want you to live your best life. This is why we work hard to offer a comprehensive benefits package that provides options to meet the unique physical, emotional and financial needs of you and your family. Please take time to review this benefits guide to make the choices that are right for you.

Thank you for all that you do, every day. You are truly making a difference.

A. Jonathan Porteus, PhD
Chief Executive Officer

Important Notice: WellSpace Health has made every attempt to ensure the accuracy of the information described in this enrollment guide. This guide is not an official plan document and does not provide a complete description of your benefit plans. Any discrepancy between this guide and the insurance contracts, summary plan descriptions (SPDs) or any other legal documents that govern the plans of benefits described in this enrollment guide will be resolved according to those documents. WellSpace Health reserves the right to amend or discontinue the benefits described in this enrollment guide in the future, as well as change how eligible employees and WellSpace Health share plan costs at any time. This enrollment guide creates neither an employment agreement of any kind nor a guarantee of continued employment with WellSpace Health.

WHAT'S NEW

- **New Medical Expense Reimbursement Plan (MERP)**
  - Eliminates the need for the Solutions Plus Gap plan
- **Same great health insurance carriers, PLUS positive medical coverage updates for 2024-2025**
  - **Kaiser:** New single plan option with $0 cost-share for all services for the first $5,500 of incurred claims
  - **WHA:** New single plan option with $0 cost-share for all services for the first $5,000 of incurred claims
  - **SHP:** New single plan option with $0 cost-share for all services for the first $5,500 of incurred claims
- **Dental PPO, vision, life, and disability plans will be through Unum**, creating additional provider access points and other enhancements

You must take action **August 12 - August 23** at **paycom.com** for 2024-2025 benefits, to add or remove dependents or decline coverage.

Your current coverage **WILL NOT** continue.

HELPFUL BENEFITS INFORMATION

To learn more about your WellSpace Health benefits, scan the QR codes throughout this benefits guide.

ELIGIBILITY

You're eligible for WellSpace Health benefits as a full-time employee working at least 30 hours per week.

Eligible dependents include your:

- Spouse or domestic partner[1]
- Child(ren) up to age 26:
  - Biological and adopted child(ren) (including those placed in your home for adoption)
  - Stepchild(ren) and domestic partner's child(ren)
  - Children for whom you are responsible to provide health coverage under a qualified medical child support order
  - Child(ren) of any age that are incapable of self-support due to mental or physical disability

Review WellSpace Health's Wrap Document or carrier policies for additional details regarding eligibility, including the company's definition of domestic partner.

PROOF OF DEPENDENT ELIGIBILITY

You may be required to provide proof of eligibility for your dependents. Attempting to enroll an ineligible dependent could lead to disciplinary action, up to termination of employment. If your dependent becomes ineligible for coverage during the year, you must contact Human Resources within 30 days.

[1] Due to federal and state tax regulations, benefits provided to domestic partners are generally taxable and therefore deducted from your pay on an after-tax basis. Additionally, any premium contributions made by WellSpace Health on behalf of your domestic partner are generally considered taxable income to you. Contact Human Resources if you believe your domestic partner is exempt from federal or state taxes.

HOW TO ENROLL

HOW TO ENROLL

All benefits enrollment/change requests are made online by you through Paycom. Here are the steps to follow:

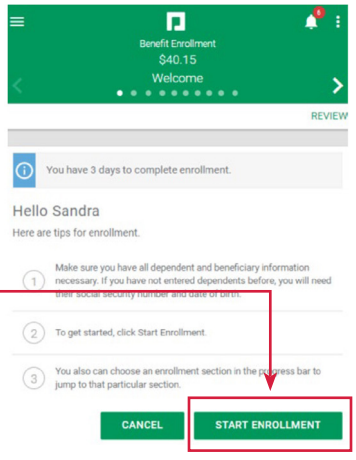
STEP 1. Visit paycom.com or download the Paycom app, register and log in.

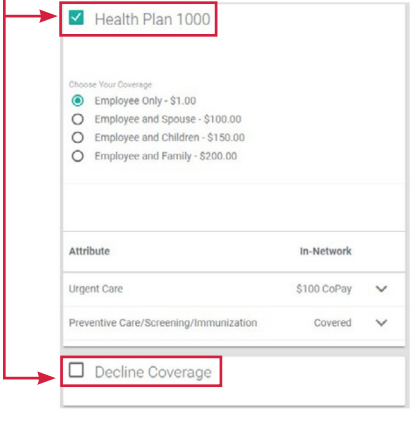
STEP 2. Within the Notification Center, select **Benefits Enrollment**.

STEP 3. Click **Start Enrollment** and enter your personal information, any dependents or beneficiaries.

STEP 4. After reading each benefit plan, choose your coverage and enroll or decline.

STEP 5. To complete enrollment, click **Finalize** then **Sign and Submit**.





MAKING BENEFIT CHANGES

There are three opportunities to make changes to your benefits:

1. AS A NEW HIRE

As a new hire, you can enroll in benefits effective the first of the month following 30 days of employment, otherwise your next opportunity to enroll will be the annual open enrollment period. Benefits that you elect will be in effect until September 30.

2. DURING THE ANNUAL OPEN ENROLLMENT PERIOD

You can make changes to your benefits each year during the annual open enrollment period (normally held in August) for benefits effective October 1 – September 30.

3. QUALIFIED CHANGE IN STATUS

Your 2024-2025 elections will remain in effect throughout the plan year unless you experience a change in status that affects eligibility for benefits or another qualified change in status (in accordance with Internal Revenue Code rules). You must request an election change within 30 days from the date of the event and may need to provide supporting documentation (such as a marriage license or birth certificate).

Examples of qualified changes in status include (but are not limited to) a change in:

- Marital status, including marriage, death of a spouse, divorce, annulment or legal separation
- Domestic partnership status, including establishment or termination of the partnership
- Number of your eligible children, including by birth, adoption, placement for adoption or death
- Eligibility status of your children (e.g., due to age)
- Gain/loss of other coverage

TERMS TO KNOW

Coinsurance – The percentage you pay for the cost of covered health care services after you have met your deductible. For example, if the coinsurance under your plan is 20%, you would pay 20% of the cost of the service and your insurance would pay the remaining 80%.

Copay – A predetermined dollar amount you pay for visits to the doctor, prescriptions and other health care providers (as specified by your plan).

Calendar Year Deductible – The amount of money you pay out of pocket during the calendar year before your insurance begins contributing money to your health care costs.

Network – A group of doctors, hospitals, labs and other providers that your health insurance contracts with so you can make visits at a pre-negotiated (and often discounted) rate.

Out-of-Pocket Maximum – The cap on your out-of-pocket costs for the calendar year. Once you've reached this amount, your plan will cover 100% of your qualified medical expenses for the remainder of the calendar year.

Plan Year – The period of time when your coverage is active (October 1 – September 30).

Premium – The amount of money that's paid for your health insurance every month. WellSpace Health pays a portion of this amount and you pay the rest via payroll deductions.

Primary Care Physician (PCP) – The provider who oversees your care and provides referrals to specialists, as needed or required.

CHOOSING THE BEST PLAN

All enrollments must be done through Paycom. In addition, paper forms are required if any of the following changes/enrollments are made. Enrollment/change forms can be found on the **MyBenefits** site.

Complete required forms and return them to Human Resources by **August 23, 2024 (if enrolling during the 2024-2025 open enrollment period)**

Changes at Open Enrollment	Action Required
Waiving medical coverage	Complete the Medical Waiver Form AND provide proof of other coverage
Enrolling a domestic partner for the first time	Complete the Domestic Partnership Affidavit
Designating anyone other than your spouse as your primary beneficiary	Complete and have your spouse sign the Unum Beneficiary Designation Form

We understand how important the right to medical coverage is for the health of you and your family. This is why we provide a number of medical plans for you to choose from. All plans include prescription drug coverage.

You have access to high-quality HMO medical plans through Kaiser, Western Health Advantage (WHA) and Sutter Health Plus (SHP). Colleagues outside of the HMO service area have access to the Anthem Preferred Provider Organization (PPO) plan, offered through WHA.

For this plan year, you will have the choice of one Kaiser plan, one Western Health Advantage plan, or one Sutter Health Plus plan. These plans are paired with a new Medical Expense Reimbursement plan (MERP), which is administered by The Difference Card, and funded by WellSpace Health. The MERP exists to substantially reduce your out-of-pocket costs when you and your family members receive care.

When you enroll in one of the health insurance plans, you (and any dependents you enroll in your health insurance plan) will automatically be enrolled in the MERP, and you will receive a Difference Card Mastercard. You and your family members will use the Difference Card Mastercard as a payment card to cover 100% of your health insurance plan related medical expenses for the first $5,000 (if you are enrolled in the WHA plan) or the first $5,500 (if you are enrolled in the Kaiser or Sutter Health Plus plan). The card can be used at the point of service or at a later date to pay provider billing statements online or by phone.

IMPORTANT: Enrolling in a WHA or SHP HMO Medical Plan?
If you are enrolling in one of the WHA or SHP HMO medical plans for the first time, **you must select a Primary Care Physician (PCP) for yourself and any dependents who will manage all of your care**. If you do not select a PCP, the carrier will select one for you and any dependents. You can change your PCP at any time by contacting WHA or SHP directly. Be sure to confirm the date your new PCP will be effective.

Note: If you are already enrolled with WHA or SHP, there is nothing you need to do during open enrollment. Your current PCP election(s) will remain.

KAISER MEDICAL PLAN

KAISER PERMANENTE®

KAISER PERMANENTE PLANS

KEY FEATURES	HMO	Difference Card Pays	You Pay
	In-Network Only		
CALENDAR YEAR DEDUCTIBLE Individual/Family	$5,500/ $11,000	1st $5,500/ 1st $11,000	$0/$0
OUT-OF-POCKET MAXIMUM Individual/Family	$7,000/$14,000	1st $5,500/ 1st $11,000	$1,500/$3,000
PRIMARY CARE VISIT	Deductible + $50	1st $5,500/ 1st $11,000	$50
SPECIALIST CARE VISIT	Deductible + $50	1st $5,500/ 1st $11,000	$50
CHIROPRACTIC CARE VISIT	$15 (30/Year)	1st $5,500/ 1st $11,000	$15 (30/Year)
ACUPUNCTURE VISIT	Not covered	Not covered	Not covered
INPATIENT HOSPITAL	Deductible + 40%	1st $5,500/ 1st $11,000	40%
OUTPATIENT SURGERY	Deductible + 40%	1st $5,500/ 1st $11,000	40%
E.R. VISIT	Deductible + 40%	1st $5,500/ 1st $11,000	40%
URGENT CARE	Deductible + $50	1st $5,500/ 1st $11,000	$50
LAB TEST	Deductible + 40%	1st $5,500/ 1st $11,000	40%
X-RAY IMAGING	Deductible + 40%	1st $5,500/ 1st $11,000	40%
ADVANCED IMAGING	Deductible + 40%	1st $5,500/ 1st $11,000	40%
PRESCRIPTION DRUGS			
RX DEDUCTIBLE Individual/Family	Combined with Medical	1st $5,500/ 1st $11,000	$0
GENERIC	Deductible + $15	1st $5,500/ 1st $11,000	$15
BRAND NAME	Deductible + 40%	1st $5,500/$11,000	40%
SPECIALTY	Deductible + 40% ($250 Max)	1st $5,500/$11,000	40% ($250 Max)
MAIL ORDER	2x Copay for 100 Day Supply	2x Copay for 100 Day Supply	2X Copay for 100 Day Supply

Difference Card is a medical expense reimbursement plan that you will receive a debit card for. You can use this card to pay for the medical and pharmacy above.

KAISER HMO WITH DIFFERENCE CARD	BI-WEEKLY CONTRIBUTIONS
EMPLOYEE ONLY	$0.00
EMPLOYEE + SPOUSE	$183.28
EMPLOYEE + CHILD(REN)	$131.96
EMPLOYEE + FAMILY	$439.85

FIND A KAISER IN-NETWORK PROVIDER

You must see a provider from within the Kaiser network to be covered. To find an in-network doctor near you, visit **kp.org**.

WHA HMO MEDICAL PLANS

Western Health Advantage

WESTERN HEALTH ADVANTAGE PLAN

KEY FEATURES	HMO	Difference Card Pays	You Pay
	In-Network Only		
CALENDAR YEAR DEDUCTIBLE Individual/Family	$4,000/$8,000	1st $5,000/1st $10,000	$0/$0
OUT-OF-POCKET MAXIMUM Individual/Family	$6,350/$12,700	1st $5,000/1st $10,000	$1,350/$2,700
PRIMARY CARE VISIT	Deductible + 40%	1st $5,000/1st $10,000	40%
SPECIALIST CARE VISIT	Deductible + 40%	1st $5,000/1st $10,000	40%
CHIROPRACTIC CARE VISIT	Deductible + $0 (20/Year)	1st $5,000/1st $10,000	$0 (20/Year)
ACUPUNCTURE VISIT	Deductible + $0 (20/Year)	1st $5,000/1st $10,000	$0 (20/Year)
INPATIENT HOSPITAL	Deductible + 40%	1st $5,000/1st $10,000	40%
OUTPATIENT SURGERY	Deductible + 40%	1st $5,000/1st $10,000	40%
E.R. VISIT	Deductible + 40%	1st $5,000/ 1st $10,000	40%
URGENT CARE	Deductible + 40%	1st $5,000/ 1st $10,000	40%
LAB TEST	Deductible + 40%	1st $5,000/ 1st $10,000	40%
X-RAY IMAGING	Deductible + 40%	1st $5,000/ 1st $10,000	40%
ADVANCED IMAGING	Deductible + 40%	1st $5,000/ 1st $10,000	40%
PRESCRIPTION DRUGS			
RX DEDUCTIBLE Individual/Family	Combined with Medical	1st $5,000/ 1st $10,000	$0
TIER 1 (GENERIC)	Deductible + 40%	1st $5,000/ 1st $10,000	40% ($500 Max)
TIER 2 (PREFERRED)	Deductible + 40%	1st $5,000/ 1st $10,000	40% ($500 Max)
TIER 3 (NON-PREFERRED)	Deductible + 40%	1st $5,000/ 1st $10,000	40% ($500 Max)
TIER 4 (SPECIALTY)	Deductible + 40% ($500 Max)	1st $5,000/ 1st $10,000	40% ($500 Max)
MAIL ORDER	90 Day Supply	90 Day Supply	90 Day Supply

Difference Card is a medical expense reimbursement plan that you will receive a debit card for. You can use this card to pay for the medical and pharmacy above.

WESTERN HEALTH HMO W/DIFFERENCE CARD	BI-WEEKLY CONTRIBUTIONS
EMPLOYEE ONLY	$0.00
EMPLOYEE + SPOUSE	$105.13
EMPLOYEE + CHILD(REN)	$75.70
EMPLOYEE + FAMILY	$252.02

FIND A WHA IN-NETWORK PROVIDER

You must see a provider from within the WHA network to be covered. To find an in-network doctor near you, visit **westernhealth.com**.

WHA ADVANTAGE PROGRAMS

Western Health Advantage

WHA PROGRAMS

When you and your family are enrolled in a Western Health Advantage (WHA) medical plan, you have access to these additional health benefits that support your whole health – all at no cost to you.

VIRTUAL PHYSICAL THERAPY – Kaia Health™ offers a mobile physical therapy app for acute and chronic musculoskeletal (MSK) pain. With Kaia, you receive physical therapy through your mobile phone or tablet. Adults with acute or chronic pain—in their neck, shoulders, back, hips, wrists and knees—may benefit from timely physical therapy through artificial intelligence/AI-driven physical therapy instruction and monitoring. This innovative new technology is designed by orthopedists and physical therapists and shows real promise. Learn more at **mywha.org/Kaia**.

ONLINE TOOLS TO MANAGE HYPERTENSION – Livongo® for Hypertension program delivers tools and coaching to help adults living with hypertension better monitor and manage their blood pressure through a mobile, web-based portal. Livongo includes a suite of tools including a connected blood pressure monitor, real-time insights after each reading, health education, and one-on-one support from expert coaches. When you sign up, you get an advanced blood pressure monitor sent to your home; personalized insights into blood pressure readings; one-on-one coaching and guidance for making changes to help you develop healthy habits in your diet and lifestyle; all in an easy-to-use app and dashboard. Learn more at: **mywha.org/Livongo**.

NUTRITIONAL COUNSELING BENEFIT – There are a number of reasons to consider counseling for nutrition, but when your weight impacts your health and lifestyle, then it's important to look for support from your doctor and your health plan. WHA members receive weight management support, whether for addressing obesity, eating disorders, or needed weight gain. Talk with your doctor, as you must meet specified medical criteria and demonstrate a documented readiness to make nutrition and lifestyle changes. If your doctor refers you to a nutritionist, you will have the same cost-sharing that you would have for a primary care office visit. Eligible members get three initial visits with a nutritionist; with additional visits based on documented improvement. Learn more at: **mywha.org/nutrition**.

FAMILY AND DIVERSITY SUPPORT BENEFIT – Planning for a routine pregnancy may require support services. Western Health Advantage's Family and Diversity Support Benefit provides assistance for members seeking pregnancy or for members with a known rare and severe genetic trait who may need support to conceive for a 50% copayment (does not contribute to the annual out-of-pocket maximum). Services include pregnancy support of up to three cycles of artificial insemination or sperm collection per lifetime and medications for ovarian stimulation, including basic laboratory and imaging tests related to fertility workups, and pre-implantation genetic testing. Learn more at: **mywha.org/family-diversity** or call **888.563.2250**.

SUTTER HEALTH HMO PLAN

Sutter Health

SUTTER HEALTH PLAN

KEY FEATURES	HMO	Difference Card Pays	You Pay
	In-Network Only		
CALENDAR YEAR DEDUCTIBLE Individual/Family	$5,500/ $11,000	1st $5,500/ 1st $11,000	$0/$0
OUT-OF-POCKET MAXIMUM Individual/Family	$6,500/$13,000	1st $5,500/ 1st $11,000	$1,000/$2,000
PRIMARY CARE VISIT	$50	1st $5,500/ 1st $11,000	Remaining Amount
SPECIALIST CARE VISIT	$50	1st $5,500/ 1st $11,000	Remaining Amount
CHIROPRACTIC CARE VISIT	$15 (Combined 20/Year)	1st $5,500/ 1st $11,000	Remaining Amount
ACUPUNCTURE VISIT	$15 (Combined 20/Year)	1st $5,500/ 1st $11,000	Remaining Amount
INPATIENT HOSPITAL	Deductible + 30%	1st $5,500/ 1st $11,000	Remaining Amount
OUTPATIENT SURGERY	Deductible + 30%	1st $5,500/ 1st $11,000	Remaining Amount
E.R. VISIT	Deductible + $150	1st $5,500/ 1st $11,000	Remaining Amount
URGENT CARE	$50	1st $5,500/ 1st $11,000	Remaining Amount
LAB TEST	$10	1st $5,500/ 1st $11,000	Remaining Amount
X-RAY IMAGING	$50	1st $5,500/ 1st $11,000	Remaining Amount
ADVANCED IMAGING	Deductible + $100	1st $5,500/ 1st $11,000	Remaining Amount
PRESCRIPTION DRUGS			
RX DEDUCTIBLE Individual/Family	$0	1st $5,500/ 1st $11,000	$0
TIER 1 (GENERIC)	$10	1st $5,500/ 1st $11,000	Remaining Amount
TIER 2 (PREFERRED)	$30	1st $5,500/ 1st $11,000	Remaining Amount
TIER 3 (NON-PREFERRED)	$60	1st $5,500/ 1st $11,000	Remaining Amount
TIER 4 (SPECIALTY)	30% ($250 Max)	1st $5,500/ 1st $11,000	Remaining Amount
MAIL ORDER	2x Copay for 100 Day Supply	2x Copay for 100 Day Supply	2x Copay for 100 Day Supply

Difference Card is a medical expense reimbursement plan that you will receive a debit card for. You can use this card to pay for the medical and pharmacy above.

SUTTER HEALTH HMO W/DIFFERENCE CARD	BI-WEEKLY CONTRIBUTIONS
EMPLOYEE ONLY	$0.00
EMPLOYEE + SPOUSE	$172.77
EMPLOYEE + CHILD(REN)	$124.39
EMPLOYEE + FAMILY	$414.52

FIND A SUTTER HEALTH PLUS IN-NETWORK PROVIDER

You must see a provider from within the SHP network to be covered. To find an in-network doctor near you, visit **sutterhealthplus.com**.

ANTHEM PPO PLANS

(for employees outside of the Kaiser, WHA, or SHP service areas)

Anthem

ANTHEM PPO PLANS

KEY FEATURES	In-Network	Out-of-Network
CALENDAR YEAR DEDUCTIBLE Individual/Family	$1,000/$3,000	$3,000/$9,000
OUT-OF-POCKET MAXIMUM Individual/Family	$5,000/$10,000	$15,000/$30,000
PRIMARY CARE VISIT	$35	Deductible + 40%
SPECIALIST CARE VISIT	$55	Deductible + 40%
CHIROPRACTIC CARE VISIT	$35 (30/Year)	Deductible + 40%
ACUPUNCTURE VISIT	$35 (20/Year)	Deductible + 40%
INPATIENT HOSPITAL	Deductible + 20%	Deductible + 40%
OUTPATIENT SURGERY	Deductible + 20%	Deductible + 40%
E.R. VISIT	$150 + Deductible + 20%	Paid as In Network
URGENT CARE	$35	Deductible + 40%
LAB TEST	Deductible + 20%	Deductible + 40%
X-RAY IMAGING	Deductible + 20%	Deductible + 40%
ADVANCED IMAGING	Deductible + 20%	Deductible + 40%
PRESCRIPTION DRUGS		
RX DEDUCTIBLE Individual/Family	$0	
TIER 1 (GENERIC)	$5/$20	50% ($250 Max)
TIER 2 (PREFERRED)	$30	50% ($250 Max)
TIER 3 (NON-PREFERRED)	$50	50% ($250 Max)
TIER 4 (SPECIALTY)	30% ($250 Max)	50% ($250 Max)
MAIL ORDER	2X Copay for 90 Day Supply	Not Covered

*Visit **MyBenefits** for more details, including summaries of benefits and coverage (SBCs).*

ANTHEM PPO	BI-WEEKLY CONTRIBUTIONS
EMPLOYEE ONLY	$84.82
EMPLOYEE + SPOUSE	$240.61
EMPLOYEE + CHILD(REN)	$197.00
EMPLOYEE + FAMILY	$458.28

FIND AN ANTHEM IN-NETWORK PROVIDER

With the Anthem PPO plan, you'll save the most money when you stay in-network. To find an in-network doctor near you, visit **anthem.com** Click on "**Find Care**" then click on "**Guests**". Answer the four questions: Medical/Select State/Medical (Employer-Sponsored)/National PPO (BlueCard PPO).

PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG BENEFITS

Your prescription drug coverage is included as part of the medical plan option you select. You should always use a participating pharmacy and review the plan's formulary (list of covered medications) to save the most money. You can access a list of pharmacies through your medical plan's website or by calling their member services number.

The medical plans have "tiered" copays for prescriptions, meaning you pay a different set amount based on the class/group your medication falls under. Generic drugs generally have the lowest copays, and brand name drugs generally have the highest copays.

VIRTUAL MEDICAL VISITS

24/7 telehealth services allow you to visit with providers from the comfort of your home – or wherever you are! You can speak to licensed doctors by web, phone or mobile app.

Virtual visits are a convenient option when you or your dependents have a minor medical issue (such as pink eye, rash, sore throat or allergies) and aren't up to seeing the doctor in person. Doctors can even issue prescriptions when necessary.

It's also **less expensive than visiting an urgent care center or emergency room**. You can access this benefit depending on which medical plan you're enrolled in.

VIRTUAL DENTAL VISITS

Virtual dental visits through **teledentistry.com**. 24/7 dental care for dental emergencies when an in-person visit isn't an option. Available for active dental members. **Note:** Virtual dentist visits are a preventive service and subject to the policy year maximum benefit.

UNUM DENTAL

Receive expert care in the comfort of your home or current location, our virtual consultations offer prompt attention and expert dental advice. Visit **unumdentalcare.com** and click Virtual Dental Visits to get started.

WHA: TELADOC

Contact your doctor's office first to learn about virtual care visits available to you. More information can be found at **mywha.org/virtualvisits**.

WHA: REVERSE TYPE 2 DIABETES WITH VIRTA HEALTH

This program helps individuals lower their blood sugar and hemoglobin A1C. Virta Health is available at no additional cost to you. To see if you qualify for this program, visit **mywha.org/Virta** and complete a short online application.

SHP: VIDEO VISIT OPTIONS

1. Download the **My Health Online (MHO)** mobile app
2. Log in to MHO at **mho.sutterhealth.org** and select **Schedule Video Visit**

At the time of your appointment, log in, select your scheduled video visit and click **Begin Video Visit**.

KAISER: INTERACTIVE VIDEO VISIT OPTIONS

1. Visit **kp.org/mydoctor/videovisits** on your computer or smartphone
2. Download the **Kaiser Permanente** mobile app

When ready, click **Join Your Video Visit** to be connected with a doctor.

DENTAL PLANS

You can choose from two dental plans through DeltaCare USA HMO and Unum PPO. Each plan has unique advantages, so understanding the differences can help you choose the coverage that best meets your needs.

The information below is a summary of coverage only.

PLAN	PLAN FEATURES
DeltaCare USA HMO	■ Provides benefits only if you see an in-network dentist ■ Requires you to choose a primary care dentist to coordinate all your care ■ Provides benefits based on a copay schedule (available on the MyBenefits site) ■ Visit **deltadentalins.com** to find a provider near you
Unum PPO	■ Allows you to receive care from a dentist in the network or outside the network ■ Pays a portion of your expenses after you meet your annual deductible, except for preventive care which is covered at 100% ■ Visit **unumdentalcare.com** to find a provider near you

PLAN	DeltaCare USA HMO	UNUM PPO	
Key Features	In-Network Only	In-Network	Out-of-Network
DEDUCTIBLE (Individual/Family)	None	$50/$150 (Waived for Preventive)	$50/$150 (Waived for Preventive)
ORTHO LIFETIME MAXIMUM	Unlimited	$1,5000	$1,5000
PLAN YEAR MAXIMUM	Unlimited	$1,0000	$1,0000
PREVENTIVE	Copay Examples: Office Visit Exams, X-Rays & Cleanings: $0 Resin, 1 Anterior Surface: $0 Root Canal, Anterior: $55 Porcelain Crown: $240	100%	100%
BASIC		80%	80%
MAJOR		50%	50%
ORTHO (Adult & Child)	Child: $1,700 Copay Adult: $1,900 Copay	50%	50%
MAXIMUM ALLOWABLE CHARGE (Out-of-Network)	In-Network Only	-	95th UCR

With the dental PPO plan, during each benefit year, if a member receives at least one cleaning, one regular exam, and their total dental claims are below the threshold limit, a portion of the annual maximum will automatically carry over to the next year.

Base Annual Maximum	Claim Threshold Limit	Annual Maximum Carryover Amount	Lifetime Carryover Maximum Balance
$1,000	$500	$250	$1,000

UNUM DENTAL PPO	BI-WEEKLY CONTRIBUTIONS
EMPLOYEE ONLY	$13.30
EMPLOYEE + SPOUSE	$22.97
EMPLOYEE + CHILD(REN)	$24.31
EMPLOYEE + FAMILY	$42.48

DELTACARE USA DHMO	BI-WEEKLY CONTRIBUTIONS
EMPLOYEE ONLY	$0.00
EMPLOYEE + SPOUSE	$0.00
EMPLOYEE + CHILD(REN)	$0.00
EMPLOYEE + FAMILY	$0.00

VISION PLANS

You and your dependents have access to vision coverage through Unum, which utilizes the EyeMed network. You pay the full premium for this coverage. You can see any provider you choose, but vision care from an EyeMed provider will cost you the least in out-of-pocket costs. To find a participating provider near you, visit **member.eyemedvisioncare.com/unum/en**. The information below is a summary of coverage only.

	BASE PLAN		BUY-UP PLAN	
KEY FEATURES	In-Network	Out-of-Network	In-Network	Out-of-Network
ANNUAL EXAM	$10	Up to $40	$10	Up to $40
SINGLE LENSES	$15	Up to $30	$15	Up to $30
BIFOCAL LENSES	$15	Up to $50	$15	Up to $50
TRIFOCAL LENSES	$15	Up to $70	$15	Up to $70
CONTACT LENSES	$130 Allowance	Up to $130	$130 Allowance	Up to $130
FRAMES	$130 Allowance	Up to $91	$130 Allowance	Up to $91
FREQUENCY				
ANNUAL EXAM	12 Months		Once every 12 months	
SINGLE LENSES	12 Months			
BIFOCAL LENSES	12 Months			
TRIFOCAL LENSES	12 Months			
CONTACT LENSES	12 Months			
FRAMES	24 Months			

*Essential medical eye care includes detection, treatment and management of ocular and/or systemic conditions that cause visual symptoms. For symptoms such as red eyes, swollen lids, ocular trauma, flashes/floaters and other qualified conditions, you can receive care from your vision provider instead of your primary care physician.

UNUM VISION BASE	BI-WEEKLY CONTRIBUTIONS
EMPLOYEE ONLY	$3.50
EMPLOYEE + SPOUSE	$6.01
EMPLOYEE + CHILD(REN)	$6.13
EMPLOYEE + FAMILY	$9.89

UNUM VISION BUY-UP	BI-WEEKLY CONTRIBUTIONS
EMPLOYEE ONLY	$6.17
EMPLOYEE + SPOUSE	$10.57
EMPLOYEE + CHILD(REN)	$10.79
EMPLOYEE + FAMILY	$17.40

THE DIFFERENCE CARD MEDICAL EXPENSE REIMBURSEMENT PLAN

If you enroll in one of the Kaiser, Western Health Advantage (WHA), or Sutter Health Plus (SHP) plans, you will automatically be enrolled in the WellSpace Health MERP, which is administered by The Difference Card, and funded by WellSpace Health. The MERP exists to cover the majority of the expenses you will incur if and when you use your health insurance plan.

- You will receive a Difference Card Mastercard in the mail, which you can use to pay for 100% of your health insurance plan related medical expenses up to a specific dollar amount depending on the plan that you are enrolled in. Any service that is covered by your health insurance plan is an eligible expense that you can use your Difference Card Mastercard to pay for. The card can be used as a payment method at the point of service on the day you receive care, or it can be used to pay provider billing statements you receive at a later date. You can use the card to pay online or by phone.
- **What do I need to do once I receive my Difference Card Mastercard?** Once you are enrolled in the Difference Card MERP, register your account. The mobile app is recommended. Use the QR code to download. You can also register an account online by visiting the website at **differencecard.com**. Please note that the mobile app and online member portal will require two separate registrations.
- **Will my spouse and/or children receive Difference Cards?** Each member enrolled in the medical plan is automatically enrolled in the Difference Card program and will receive a card. A card will be mailed to the member and their spouse. If you have dependents under age 18, they will be linked to your card. If you have eligible dependents over age 18, they can receive their own card, by contacting **888.343.2110**. These cards should be accepted at the provider's office if they accept Mastercard. These cards are good for 3 years and are activated upon the first swipe.
- **What happens if I lose my Difference Card Mastercard?** Call **888.343.2110** to request a replacement card.
- **What happens if I need to pay for a service and I do not have my Difference Card?** You can ask the provider to bill you and then pay the provider billing statement with your Difference Card Mastercard at a later date. If necessary, you can use your personal credit card, and then submit a manual reimbursement request. You can sign up for direct deposit, and the reimbursement funds will be direct deposited into your bank account approximately 24 hours after the request has been processed.
- **How do I submit a manual reimbursement request?** Take a picture of the provider billing statement or insurance carrier Explanation of Benefits (EOB) and upload the picture when submitting the reimbursement request via the Difference Card mobile app. You can also download a PDF of the billing statement or EOB, and upload the PDFs when submitting the reimbursement request via the Difference Card portal.
- **Do I need to submit receipts each time I use the Difference Card?** The Difference Card Mastercard is a smart-card and most transactions can be "auto substantiated", meaning additional documentation will not be required to prove to Difference Card that the card is being used appropriately. Difference Card will notify you via mail or via your member portal if you need to submit documentation in order to substantiate a claim.

SCAN FOR THE DIFFERENCE CARD MOBILE APP

ADVOCACY

BenefitsVIP
Help starts here.

HELP STARTS HERE

BenefitsVIP is a powerful, one-stop contact center staffed by seasoned professionals. Your dedicated team of employee benefits advocates is ready to help you and your family members resolve your benefits issues.

Let BenefitsVIP help you and your family members with:

- Benefits questions
- ID card requests
- Billing issues
- Claims resolution
- Prescription issues
- Provider network questions
- ...and much more!

You can contact BenefitsVIP at **866.286.5354**, Monday through Friday, 5:30 a.m. – 5:00 p.m. (PST) You can also email them at **answers@benefitsvip.com** or you can access them via the BenefitsVIP website **www.benefitsvip.com** or by scanning the QR code here:

You also have access to Rightway, the BenefitsVIP mobile app, which you can download by scanning the QR code here:

QUESTIONS ANSWERED HERE

COMPLETELY CONFIDENTIAL! Your dedicated BenefitsVIP advocates understand your benefit plans and are able to answer benefit questions and quickly resolve claims and eligibility issues. A majority of inquiries are resolved the same day and all calls adhere to privacy best practices.

Benefitsvip.com
Request member assistance and order ID cards in a click.

HealthDiscovery.org
Get vital, useful and fun health insurance and wellness facts.

BASIC LIFE & AD&D
VOLUNTARY LIFE & AD&D

Better benefits at work.

BASIC LIFE AND AD&D

WellSpace Health provides Basic Life and Accidental Death and Dismemberment (AD&D) insurance. These benefits provide financial assistance in the amount of $50,000 for you and your beneficiaries in the event of disability, accident or death. Coverage is provided through Unum at no cost to you.

VOLUNTARY LIFE AND AD&D

You may purchase optional (additional) life insurance for yourself, your spouse or domestic partner and your child(ren) if the basic coverage alone doesn't meet your needs.

Your per payroll costs are calculated based on age. You're only able to purchase supplemental spouse/ domestic partner and child life coverage after you purchase supplemental life coverage for yourself.

- **Employee:** may purchase coverage in increments of $10,000 up to the lesser of $500,000 or five times your annual earnings. Up to $200,000 guaranteed issue (no medical underwriting) for new hires and those electing coverage during the 2024/2025 plan year Open Enrollment).
- **Spouse/Domestic Partner:** may purchase coverage equal to 50% of employee's benefit or $50,000 (whichever is less) in increments of $5,000
- **Dependent Child(ren):** may purchase coverage equal to $250 for ages 14 days to 6 months or $10,000 for ages 6 months to 26 years – coverage is $1.00 per payroll per $10,000 of coverage

Note: If you are currently enrolled and you age into a new band (i.e. 45-49), your per payroll premium will increase.

Per Payroll Rate Calculation Example

34-year-old employee elects $20,000 coverage: $20,000 / $1,000 x $0.046 = **$0.92** per payroll

AGE	BI-WEEKLY RATE PER $1,000 OF COVERAGE*
0-24	$0.032
25-29	$0.037
30-34	$0.046
35-39	$0.051
40-44	$0.074
45-49	$0.111
50-54	$0.208
55-59	$0.318
60-64	$0.346
65-69	$0.605
70-99	$1.542
CHILD RATE	$0.018

*Rates for both employee and spouse are based on the employee's age. Rates include Life and AD&D.

BASIC LIFE W/AD&D	$0

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Flexible Spending Accounts (FSAs) allow you to set aside money from your paycheck to pay health care and dependent care expenses with tax-free dollars. When you contribute to FSAs, your pre-tax contributions reduce your taxable income. FSAs work like a savings account. Here's how you save:

- A pretax payroll deduction amount of your choice (up to the IRS maximum) is deposited into your FSA
- The amount you contribute to either or both FSAs is deducted from your paycheck before federal, state, local and Social Security taxes are withheld
- When you have an eligible expense, reimbursement from your account is tax-free. All expenses must be incurred prior to the end of the plan year to qualify for reimbursement

Our FSA year ends on September 30. All claims must be submitted no later than October 30, 2024 (deadline is subject to change by vendor) for the 2024-2025 plan year. For a list of eligible expenses, claim filing deadlines and other information regarding your FSAs, visit **benefitresource.com** or scan the QR code below.

HEALTH CARE FSA

The health care FSA can be used to pay for medically necessary expenses not covered by your medical, dental or vision plans, including:

- Deductibles, copays and coinsurance
- Dental and orthodontia expenses
- Prescription glasses, contact lenses and laser vision correction
- Prescription drug copays
- Some over-the-counter medications

You may contribute up to $3,200 to the health care FSA during the 2024-2025 plan year. You may carry over up to $610 of your current unused health care FSA funds to the new 2024-2025 plan year. Any balance in excess of $610 at the end of the current 2023-2024 plan year will be forfeited. The amount you may carry over from the 2024-2025 plan year to the 2025-2026 plan year will increase to $640.

DEPENDENT CARE FSA

The dependent care FSA can reimburse you for eligible dependent care expenses. Eligible dependent care is for:

- Dependent children under age 13 who live with you most of the time and do not provide more than one-half of their support
- Dependents of any age who are incapable of self-care

Care must be provided while you (and your spouse, if you are married) work, look for work or attend school full-time. Eligible expenses include care in your home by an eligible provider or at a licensed facility. You won't be reimbursed for residential or "sleep-away" care, nursing home care or for babysitting when you are not at work.

You may contribute up to $5,000 to the dependent care FSA in the 2024-2025 plan year. However, if your spouse has access to another dependent care FSA, your combined contribution may not exceed $5,000. If you're married and file separate tax returns, each spouse may contribute $2,500. You may not roll over any unused dependent care FSA funds remaining at the end of the plan year to the next plan year.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Better benefits at work.

Life happens and we've all experienced some type of personal problem, concern, or emotional crisis at some point. With your Employee Assistance Program (EAP) and Work/Life Balance services from HealthAdvocate, you have access to a wide range of supportive services that help you lead a happier and more productive life at home and at work.

LICENSED PROFESSIONAL COUNSELING

A Licensed Professional Counselor* can help you with:

- Stress, depression, anxiety
- Relationship issues, divorce
- Anger, grief and loss
- Job stress, work conflicts
- Family and parenting problems
- Addiction, eating disorders, mental illness

LOCAL RESOURCES AND SUPPORT

Work/Life Specialists find support services and local resources to help with:

- Child and elder care
- Legal concerns
- Financial issues
- Time management
- Relocation issues
- Identity Theft

EMPLOYEE WELLNESS PROGRAM

Concern
GuidanceResources®

You and your dependents may receive assistance with managing work/life balance and emotional health needs with our EAPs. These no-cost, confidential programs may help with a wide array of concerns, including finding elder care, relationship and family issues, general stress, personal loss, legal support, financial hardship, identity theft recovery, depression and parenting.

All Employees: Concern EAP. Receive up to five in-person counseling sessions per member, per issue and 24/7 phone assistance. Call **800.344.4222**

Visit **concernresiliencehub.com** for help during times of stress and change.

Coaching from Concern EAP. Get up to four 30-minute sessions by phone with a certified coach.

Visit **https://employees.concernhealth.com** for access to coaching and topics that impact daily life.

Employees Working 30+ Hours per Week: EAPConnect. Receive up to three in-person counseling sessions per issue, per year and 24/7 phone assistance.

Call **888.628.4824** or visit **guidanceresources.com**

Username: LFGsupport **Password:** LFGsupport1

CONCERN WELLNESS	$0

TRAVEL INSURANCE

Better benefits at work.

If you experienced a medical emergency while traveling, would you know whom to call?

Whenever you travel 100 miles or more from home — to another country or just another city — be sure to pack your worldwide emergency travel assistance phone number. Travel assistance speaks your language, helping you locate hospitals, embassies and other "unexpected" travel destinations. Add the number to your cell phone contacts, so it's always close at hand. Just one phone call connects you and your family to medical and other important services 24 hours a day.

Use your travel assistance phone number to access:

- Hospital admission assistance*
- Emergency medical evacuation
- Prescription replacement assistance
- Transportation for a friend or family member to join a hospitalized patient
- Care and transport of unattended minor children
- Assistance with the return of a vehicle
- Emergency message services
- Critical care monitoring
- Emergency trauma counseling
- Referrals to Western-trained, English-speaking medical providers
- Legal and interpreter referrals
- Passport replacement assistance

Whether traveling for business or pleasure, one phone call connects you to:

- Multilingual, medically certified crisis management professionals
- A state-of-the-art global response operations center
- Qualified medical providers around the world

If you need travel assistance anywhere in the world, contact us day or night.

Within the U.S. **800.872.1414**

Outside the U.S. (U.S. access code) **+609.986.1234**

Via e-mail: **medservices@assistamerica.com**

LEGAL & IDENTITY THEFT

LegalShield

IDShield

LegalShield

Legal assistance for some of the most frequently needed personal legal matters —with no waiting periods, no deductibles, and no claim forms, when using a Network Attorney for a covered matter.

Affordable legal protection at your fingertips! LegalShield provides you and your family the legal protection you not only need but deserve.

The LegalShield plan provides benefits for the following:

- Estate planning
- Family
- Auto
- Financial
- Home
- General assistance

IDShield

Identity theft insurance is a protective financial product that's designed to cover the expenses that you may incur after being defrauded.

Affordable identity theft protection at your fingertips! IDShield provides the identity theft protection and identity restoration services you not only need but deserve.

The IDShield plan includes the following covered services:

- Monitored information
- Monitoring and detection
- Alerts
- Unlimited consultation
- Comprehensive identity restoration
- General assistance

Products may be purchased individually or as a package.

For more information contact our independent associate, Linda Masoli at **masoli@legalshieldassociate.com** or **650.642.4444**.

LEGAL SHIELD	BI-WEEKLY CONTRIBUTIONS
EMPLOYEE	$4.13
EMPLOYEE + FAMILY	$8.75

ID SHIELD	BI-WEEKLY CONTRIBUTIONS
EMPLOYEE	$7.82
EMPLOYEE + FAMILY	$8.75

ID & LEGAL SHIELD	BI-WEEKLY CONTRIBUTIONS
EMPLOYEE	$11.95
EMPLOYEE + FAMILY	$15.65

LONG-TERM DISABILITY (LTD)

Long-Term Disability (LTD) insurance replaces a portion of your income if you have an accident or illness that prevents you from working for an extended period. The benefits will coordinate with any other income benefits an insured employee receives. WellSpace Health offers this benefit to eligible employees at no cost.

UNUM	
Your Benefit	60% of monthly pre-disability earnings, up to a maximum of $15,000 per month.
When Benefit Begins	After 90 days of disability.
Definition of Disability	You're considered totally disabled if (due to injury or illness) you're unable to perform each of the main duties of your own occupation (up to 24 months). Following 24 months, the definition of total disability becomes the inability to perform any occupation for which you're reasonably suited based on your experience, education or training.
Pre-existing Conditions	Any sickness or injury for which you have received medical treatment, consultation, care or services during the three months prior to the coverage effective date.

LONG-TERM DISABILITY	BI-WEEKLY CONTRIBUTIONS
PER $100	$0

401(k) RETIREMENT SAVINGS PLAN

WellSpace Health's 401(k) plan is a great way to save for retirement. We offer this plan to employees who have completed their introductory period with WellSpace Health.

We match 25% of your deferred 401(k) contribution. All new hires will be automatically enrolled at 1% after their introductory period. You may opt out by contacting your Human Resources Department.

For information regarding eligibility, contributions, benefits, and tax status, contact your Human Resources Representative. All eligible participants will receive a summary plan description. WellSpace Health reserves the right to change this plan, including our employer contribution, at any time.

NOTICES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORN'S 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA, ALSO KNOWN AS JANET'S LAW)
Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.
Call your Plan Administrator for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)
QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

SPECIAL ENROLLMENT RIGHTS (HIPAA)
If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)
If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

MICHELLE'S LAW
Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage.
The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:
1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008
This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:
The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)
GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual.
GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record, and may be disclosed to third parties only in very limited situations.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers who provide medical coverage to their employees to offer such coverage to employees and covered family members on a temporary basis when there has been a change in circumstances that would otherwise result in a loss of such coverage [26 USC §4980B] This benefit, known as "continuation coverage," applies if, for example, dependent children become independent, spouses get divorced, or employees leave the employer.

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT (CHIPRA)
Effective April 1, 2009 employees and dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:
The employee's or dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminates because the individual cease to be eligible. The employee or dependent becomes eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program). Employees must request this special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

PREMIUM ASSISTANCE UNDER MEDICAID AND 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

NOTICES

children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace.
For more information, visit www.healthcare.gov. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.
If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.
If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711

Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

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

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-partyliability/childrens-health-insurance-program-reauthorizationact-2009-chipra
Phone: 678-564-1162, Press 2

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

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaida-to-z/hipp
HIPP Phone: 1-888-346-9562

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

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPPPROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

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

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programs-andservices/other-insurance.jsp
Phone: 1-800-657-3739

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

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

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

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programsservices/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

NOTICES

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

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
WWebsite: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access
Phone: 1-800-250-8427

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

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

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

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

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

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)
U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512. The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

MONTHLY CONTRIBUTIONS

ANTHEM PPO	
EMPLOYEE ONLY	$183.78
EMPLOYEE + SPOUSE	$521.32
EMPLOYEE + CHILD(REN)	$426.84
EMPLOYEE + FAMILY	$992.94

KAISER HMO WITH DIFFERENCE CARD	
EMPLOYEE ONLY	$0.00
EMPLOYEE + SPOUSE	$397.10
EMPLOYEE + CHILD(REN)	$285.91
EMPLOYEE + FAMILY	$953.02

SUTTER HEALTH HMO W/DIFFERENCE CARD	
EMPLOYEE ONLY	$0.00
EMPLOYEE + SPOUSE	$374.34
EMPLOYEE + CHILD(REN)	$269.52
EMPLOYEE + FAMILY	$898.14

WESTERN HEALTH HMO W/DIFFERENCE CARD	
EMPLOYEE ONLY	$0.00
EMPLOYEE + SPOUSE	$227.78
EMPLOYEE + CHILD(REN)	$164.03
EMPLOYEE + FAMILY	$546.05

DELTACARE USA DHMO	
EMPLOYEE ONLY	$0.00
EMPLOYEE + SPOUSE	$0.00
EMPLOYEE + CHILD(REN)	$0.00
EMPLOYEE + FAMILY	$0.00

UNUM DENTAL PPO	
EMPLOYEE ONLY	$28.81
EMPLOYEE + SPOUSE	$49.77
EMPLOYEE + CHILD(REN)	$52.67
EMPLOYEE + FAMILY	$92.05

UNUM VISION LOW	
EMPLOYEE ONLY	$7.59
EMPLOYEE + SPOUSE	$13.02
EMPLOYEE + CHILD(REN)	$13.29
EMPLOYEE + FAMILY	$21.42

UNUM VISION HIGH	
EMPLOYEE ONLY	$13.36
EMPLOYEE + SPOUSE	$22.90
EMPLOYEE + CHILD(REN)	$23.38
EMPLOYEE + FAMILY	$37.70

ID SHIELD	
EMPLOYEE ONLY	$8.95
EMPLOYEE + FAMILY	$18.95

LEGAL SHIELD	
EMPLOYEE ONLY	$16.95
EMPLOYEE + FAMILY	$18.95

ID & LEGAL SHIELD	
EMPLOYEE ONLY	$25.90
EMPLOYEE + FAMILY	$33.90

CONCERN WELLNESS	$0

BASIC LIFE W/AD&D	$0

LONG-TERM DISABILITY	$0

CONTACTS

CONTACT	GROUP NUMBER	PHONE NUMBER	WEBSITE/EMAIL	MOBILE APP
Human Resources: LaRee Thomason		916.737.5591	lthomason@wellspacehealth.org	
MEDICAL				
Kaiser	1520	800.464.4000	kp.org	
Western Health Advantage (WHA)	108261	888.563.2250	westernhealth.com memberservices@westernhealth.com	
Sutter Health Plus (SHP)	032409	855.315.5800	sutterhealthplus.org	
Anthem PPO	174299M4A9	844.783.0927	anthem.com	
The Difference Card		888.243.2110	thedifferencecard.com	
DENTAL				
Unum		866.679.3054	unumdentalcare.com	
DeltaCare USA DHMO	79352	800.422.4234	deltadentalins.com	
VISION				
Unum		866.679.3054	member.eyemedvisioncare.com/unum/en	
LIFE AND DISABILITY				
Unum		866.679.3054	unum.com	
EMPLOYEE ASSISTANCE PROGRAMS (EAP)				
Concern Wellness		800.344.4222	concern-eap.com	
Unum EAP		800.854.1446	unum.com/lifebalance	
LegalShield & ID Shield				
Unum	0103973	650.642.4444	legalshield.com	
FLEXIBLE SPENDING ACCOUNTS (FSAs)				
Benefit Resource, Inc.		800.473.9595	benefitresource.com	
COBRA QUESTIONS				
Benefit Resource, Inc.		800.473.9595	benefitresource.com	

Download on the App Store GET IT ON Google Play

NOTES

NOTES

THANK YOU!

WELLSPACE HEALTH

We see YOU.