



2025 BENEFITS GUIDE

City of Santa Rosa
California

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MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Plan Information section for more details.

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GETTING STARTED

2025 BENEFITS

January 1, 2025
through
December 31, 2025

IMPORTANT NOTE:

This guide is a summary overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan documents including your benefit summaries, summary of benefits and coverage (SBCs) and summary plan descriptions (SPDs). The plan documents determine how all benefits are paid.

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, the City of Santa Rosa will support you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, retirement benefits, and more.

You'll find tips to help you understand your benefits eligibility, medical coverage, save time and money on healthcare, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

WHO'S ELIGIBLE FOR BENEFITS?



Employees

You are eligible if you are a part-time/full-time employees working 20 or more hours per week.

Eligible dependents

- Legally married spouse.
- Registered Domestic Partner (RDP), where applicable by state law, is eligible for coverage if you have completed a Domestic Partner Affidavit.
- Natural, adopted (including a child placed for adoption) or stepchildren, or children of a domestic partner up to age 26.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the plan documents for each benefit.

Who is not eligible

Members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Employees who work less than 20 hours per week, temporary employees not on a City of Santa Rosa payroll, contract employees, or employees residing outside the United States.
- Any individual who is covered as an employee of City of Santa Rosa cannot be covered as a dependent on the same medical plan, or voluntary life insurance plan.

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the 1st of the month following date of hire. You must enroll within 30 calendar days of becoming eligible. Associated premium and payroll deductions are effective on the 1st of the month following the event.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment, the one time each year that you can make changes to your benefits for any reason. New employees who wish to waive the City of Santa Rosa's benefit coverage must provide Human Resources with proof of other group coverage through the self-service benefits administration platform, BenXcel.

WHO'S ELIGIBLE FOR BENEFITS?



Benefits Eligible Employees and Medicare

By law, the City of Santa Rosa medical plans are considered the “Primary Payer” and Medicare as a “Secondary Payer” (except for employees with End-Stage Renal Disease starting with the 31st month after the start of Medicare coverage, Medicare pays first, and this Plan pays second). This means a City of Santa Rosa sponsored group health plan pays up to the limits of coverage first and the “Secondary Payer” only pays if there are costs the primary insurer didn’t cover. Because of this “coordination of benefits” between the Primary and Secondary Payers, regular hire full-time and part-time Medicare-eligible employees who receive their healthcare coverage through a City of Santa Rosa sponsored medical plan are not required to sign up for Medicare Part B or Part D when they turn 65.

City of Santa Rosa employees who become eligible for Medicare while working will have an opportunity to sign up for Medicare prior to retirement during a Medicare Special Enrollment Period without penalty. If you are over age 65 at retirement, your Medicare benefits must be effective on or prior to your retirement date. There are premium penalties if your benefits become effective after retirement, so it is recommended to begin the Medicare enrollment process no later than three months before you plan to retire.

Below are helpful resources for more information about Medicare eligibility and enrollment:

- Centers for Medicare and Medicaid Services (CMS) official Medicare handbook, “[Medicare & You](#)”
- Social Security Administration telephone 1 (800) 772-1213 and website www.SSA.gov
- [Getting Medicare when you retire](#)

BENEFITS ELIGIBILITY

Below is a table summarizing the types of benefit plans available to eligible employees by unit:

Unit	Medical	Dental	Vision	Basic Life (Lincoln)	Basic AD&D (Lincoln)	Voluntary Life & AD&D (Lincoln)	STD/PFL	LTD	Deferred Comp	Retiree Health Savings	Stipend	FSA (Health & DCAP)	EAP
2	CalPERS	Delta	VSP	\$12,000	NA	\$10k-\$500k	NA	CAPF	Elective	NA	YES	All Units	All Units
3	City Health	Delta	VSP	\$20,000	NA	\$10k-\$500k	Lincoln	Lincoln	Elective	NA	YES		
4	Teamsters	Delta	VSP	\$20,000	NA	\$10k-\$500k	Lincoln	Lincoln	Elective	NA	YES		
5	CalPERS	Delta	VSP	\$10,000	NA	\$10k-\$500k	Lincoln	PORAC	Elective	RHS #803576	YES		
6	Teamsters	Delta	VSP	\$20,000	NA	\$10k-\$500k	Lincoln	Lincoln	Elective	NA	YES		
7	Teamsters	Delta	VSP	\$20,000	NA	\$10k-\$500k	Lincoln	Lincoln	Elective	NA	YES		
8	City Health	CORE + Buy up	VSP	\$20,000	NA	\$10k-\$500k	Lincoln	Lincoln	Elective	NA	YES		
9F	CalPERS	Delta	VSP	\$30,000	\$30,000	\$10k-\$500k	Lincoln	PORAC	Elective	NA	YES		
9P	CalPERS	Delta	VSP	\$30,000	\$30,000	\$10k-\$500k	Lincoln	PORAC	Employer Paid/ Elective	RHS #803140	YES		
10	City Health	Delta	VSP	\$50,000	\$50,000	\$10k-\$500k	Lincoln	Lincoln	Elective	RHS #801904	NA		
10S	CalPERS	Delta	VSP	\$50,000	\$50,000	\$10k-\$500k	Lincoln	Lincoln	Elective	RHS #801904	YES		
11	City Health	Delta	VSP	\$50,000	\$50,000	\$10k-\$500k	Lincoln	Lincoln	Elective	RHS #801904	NA		
12	City Health	Delta	VSP	\$50,000	\$50,000	\$10k-\$500k	Lincoln	Lincoln	Employer Paid/ Elective	NA	NA		
13	City Health	Delta	VSP	\$20,000	NA	\$10k-\$500k	Lincoln	Lincoln	Elective	NA	YES		
14	City Health	Delta	VSP	\$50,000	NA	\$10k-\$500k	Lincoln	Lincoln	Elective	NA	YES		
15	City Health	Delta	VSP	\$250,000	\$250,000	\$10k-\$500k	Lincoln	Lincoln	Elective	RHS #801904	NA		
16	City Health	Delta	VSP	\$20,000	NA	\$10k-\$500k	Lincoln	Lincoln	Elective	NA	YES		
17	Teamsters	Delta	VSP	\$50,000	\$50,000	\$10k-\$500k	Lincoln	Lincoln	Elective	RHS #803140	NA		
18	Teamsters	Delta	VSP	\$50,000	\$50,000	\$10k-\$500k	Lincoln	Lincoln	Elective	RHS #803140	NA		
99	City Health	Delta	VSP	\$50,000	\$50,000	\$10k-\$500k	Lincoln	Lincoln	Elective	NA	NA		

CHANGING YOUR BENEFITS

Click to play video



LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 30 days of the date the event occurs.
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent children
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 30 days after the event.

Dependent Verification

- Dependent verification may include but is not limited to birth or adoption certificate **and** social security or ITIN number.
- Only provide first page of your prior year FEDERAL Tax Return that shows your dependents, and black out any monetary amounts. STATE Returns are not acceptable.
- Proof of marriage must be a state issued marriage license or marriage certificate (not a church issued certificate) that includes the date of your marriage.
- State Registration Certificate is required for Domestic Partnership.
- Affidavit of Parent-Child Relationship is required for eligible Parent-Child relationships.
- Birth Certificates must be state issued (not hospital issued).

ENROLLMENT AND REQUIRED DOCUMENTATION

COMMON SCENARIOS	HOW TO ENROLL	IMPORTANT TIMELINES
Marriage or Domestic Partnership	<p>To enroll a new spouse or domestic partner and eligible children of a spouse or partner, you must :</p> <ul style="list-style-type: none"> Log in to the self-service benefits portal, BenXcel Provide copies of: <ul style="list-style-type: none"> marriage certificate or certificate of state-registered domestic partnership birth certificate for each child 	<p>Change and required documentation must be submitted through the self-service benefits portal, BenXcel, within 30 days of the legal date of the marriage or partnership</p>
Birth or Adoption	<p>To enroll your newborn or newly adopted child, you must:</p> <ul style="list-style-type: none"> Log in to the self-service benefits portal, BenXcel Provide copy of the birth certificate or adoption documentation 	<p>Change and required documentation must be submitted through the self-service benefits portal, BenXcel, within 30 days of the legal date of the child's date of birth or placement of adoption</p>
Legal Guardianship or Court Order	<p>Coverage for a child under legal guardianship is effective the date guardianship takes effect, if all documentation is submitted by the 30-day deadline. Coverage per court order will be effective the date of court order, if all documentation is submitted by the 30-day deadline.</p>	<p>Change and required documentation must be submitted through the self-service benefits portal, BenXcel, within 30 days of the effective date of court order.</p>
Loss of Other Health Coverage <i>Coverage can be lost due to termination of employment, change from full-time work to part-time work, dropping other employer coverage during Open Enrollment, ineligibility for Medicare or Medicaid, unpaid leave of absence or return from military service.</i>	<p>Employees and eligible dependents who lose other coverage may enroll by:</p> <ul style="list-style-type: none"> Logging in to the self-service benefits portal, BenXcel Providing proof of loss of coverage, or documentation of lost coverage must state the date other coverage ends and the names of the individual's losing coverage. 	<p>Change and required documentation must be submitted through the self-service benefits portal, BenXcel, within 30 days of the date other coverage terminates.</p>

Late documentation and enrollment will not be processed. If you are concerned because you cannot obtain all the needed documentation, please notify your Human Resources Department immediately to discuss: benefits@srcity.org or 707-543-3060

ENROLLING FOR BENEFITS



MID YEAR CHANGES

- Any changes you make must be consistent with change in status AND you must complete the changes in BenXcel within 30 days of the date of the event (marriage, birth, etc.) occurs.
- Mid year changes are effective the first of the month following the event, note that newborns are effective on their date of birth.

Welcome to BenXcel!

BenXcel is an online system that enables you to make all your benefit decisions in one place. If you don't have access to a computer, you can access the enrollment portal from a tablet or smartphone.

Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

Getting started

- LOG IN to BenXcel
- benxcel.net

Username: Your last saved username and password or, if this is your first-time logging in, 1st letter of your first name, entire last name, entire date of birth (no dashes)

Example: rsmith01311989; (Robert Smith 01/31/1989)

Password: Your last saved password or, if this is your first-time logging in, entire last name, 1st letter of your first name entire date of birth (no dashes)

Example: smithr01311989; (Robert Smith 01/31/1989)

Company Name: CSR

- ADD your personal and dependent information.
- SELECT your benefit plans for the coming year.
- UPLOAD any necessary documents. See Enrollment and Required Documentation page for more information.
- REVIEW your choices and costs before finalizing.

Information and all forms needed to make your Benefit elections are posted online at flimp.live/CityofSantaRosa. For CalPERS specific enrollment information, visit City of Santa Rosa [Benefits page](#) for Safety employees.



MEDICAL

OUR PLANS

City Kaiser HMO

City Anthem EPO

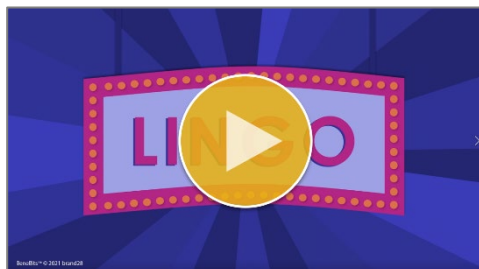
City Anthem PPO

Teamsters – Kaiser HMO

Teamsters – Anthem PPO

CalPERS – Public Safety Employees

Play the Health Lingo Game!



Which Plan Is Right For You?

That depends on your healthcare needs, favorite doctors, and budget. Here are some considerations.

Do you prefer specific doctors or hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

Consider the bottom line

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

UNDERSTANDING PLAN TYPES

City of Santa Rosa offers 3 medical plan types so that you can pick the plan that best fits your budget and healthcare needs.

Some plans (like HMOs) restrict you to in-network doctors. Other plans (like PPOs) allow you to see any doctor, but you will pay a higher coinsurance percentage if the doctor is out-of-network.

	HMO Health Maintenance Organization	EPO Exclusive Provider Organization	PPO Preferred Provider Organization
Deductible			✓
Out-of-Network Care Covered			✓
Referral Needed to see Specialist	✓		
Must select Primary Care Physician	✓		
Pros	<ul style="list-style-type: none"> • More predictable costs 	<ul style="list-style-type: none"> • Fewer restrictions than an HMO 	<ul style="list-style-type: none"> • You can go anywhere, whether in-network or out-of-network
Cons	<ul style="list-style-type: none"> • Less flexibility • No out-of-network coverage • May have to select Primary Care Physician 	<ul style="list-style-type: none"> • No out-of-network coverage 	<ul style="list-style-type: none"> • You pay more for out-of-network providers

Click to play video



All About Medical Plans

Medical plans can seem hard to understand, but once you understand the building blocks you will be able to choose the best plan for you and your dependents.

CITY OF SANTA ROSA MEDICAL PLANS

You always pay the deductible and copayment (\$). The coinsurance (%) shows what the plan pays after the deductible.

	Kaiser HMO	Anthem EPO	Anthem PPO	
	In-Network	In-Network	In-Network	Out-of-Network
Calendar Year Deductible¹ Individual / Family Embedded/Aggregate ²	\$0 / \$0 Embedded	\$0 / \$0 Embedded	\$300 / \$900 Embedded	\$300 / \$900 Embedded
Plan Year Out-of-Pocket Maximum^{1,4} Individual / Family Embedded/Aggregate ³	\$1,500 / \$3,000 Embedded	\$1,500 / \$4,500 Embedded	\$1,800 / \$3,900 Embedded	No maximum
Office Visit Primary Care Specialist	\$20 copay \$20 copay	\$25 copay \$25 copay	\$20 copay \$20 copay	60% ⁵ 60% ⁵
Online Visit	100%	\$25 copay	\$20 copay per visit	60% ⁵
Preventive Services	100%	100%	100%	60% ⁵
Chiropractic	Not covered	Not covered	80% ⁵ (combined acu limit: up to 20 visits per year)	60% ⁵ (in-network limitations apply)
Lab and X-ray	100%	\$25 copay	80% ⁵	60% ⁵ Complex imaging: up to \$800 per procedure; lab and x-ray in hospital: up to \$350 per procedure
Urgent Care	\$20 copay	100%	80% ⁵	60% ⁵
Emergency Room	\$75 copay per visit	\$75 copay (waived if admitted)	\$75 copay per visit then 80% ⁵	Covered as In-Network
Inpatient Hospitalization	\$100 copay per admission	\$250 copay per admission	80% ⁵	60% ⁵ (up to \$600 per day for non-emergency admission)
Outpatient Surgery	\$20 copay per procedure	\$250 copay per procedure	80% ⁵	60% ⁵
PRESCRIPTION DRUGS	Kaiser Pharmacy	Express Scripts	Express Scripts	
Calendar Year Deductible	N/A	N/A	N/A	N/A
Out-of-Pocket Maximum Individual / Family	\$0 / \$0	\$5,100 / \$8,700	\$4,800 / \$9,300	N/A
Retail Generic Preferred Brand Non-Preferred Brand Supply Limit	\$10 copay \$10 copay Not covered 100 days	\$10 copay \$25 copay \$55 copay 30 days ⁶	\$5 copay \$20 copay \$50 copay 30 days	Not covered
Mail Order Generic Preferred Brand Non-Preferred Brand Supply Limit	\$10 copay \$10 copay Not covered 100 days	\$20 copay \$45 copay \$95 copay 90 days	\$10 copay \$35 copay \$85 copay 90 days	Not covered

¹Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1st, 2025, through December 31st, 2025.

² An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.

³An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

⁴All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

⁵After deductible.

⁶90 Days if prescription is filled at participating Smart 90 pharmacy (CVS and Walgreens)

TEAMSTERS MEDICAL PLANS

You always pay the deductible and copayment (\$). The coinsurance (%) shows what the plan pays after the deductible.

The City of Santa Rosa offers two Teamsters Local 865 Health & Welfare Trust plans for Miscellaneous employees in units 4, 6, 7, 17 and 18. Prescription benefits for enrollees of the Teamsters Anthem plan is provided by Optum Rx. Below is a summary of benefits for the medical plans available.

	Kaiser HMO	Anthem PPO	
	In-Network	In-Network	Out-of-Network
Calendar Year Deductible¹ Individual / Family Embedded/Aggregate ²	\$0 / \$0 N/A	\$250 / \$500 Embedded	\$250 / \$500 Embedded
Plan Year Out-of-Pocket Maximum^{1,4} Individual / Family Embedded/Aggregate ³	\$1,500 / \$3,000 Embedded	\$0 / \$2,000 Aggregate	\$0 / \$0 Aggregate
Office Visit Primary Care Specialist	\$15 copay \$15 copay	\$20 copay \$20 copay	60% ⁵ 60% ⁵
Online Visit	100%	\$20 copay per visit ⁶	60% ⁵
Preventive Services	100%	No charge	Not covered
Chiropractic (20 visits per year)	\$15 copay	80% ⁵ (combined acu limit: up to 20 visits per year)	60% ⁵ (in-network limitations apply)
Lab and X-ray	100%	80% ⁵	60% ⁵ Complex imaging: up to \$800 per procedure; lab and x-ray in hospital: up to \$350 per procedure
Urgent Care	\$15 copay per visit	80% ⁵	80% ⁵
Emergency Room	\$35 copay per visit	80% ⁵	50% ⁵
Inpatient Hospitalization	100%	80% ⁵	60% ⁵
Outpatient Surgery	\$15 copay per visit	80% ⁵	60% ⁵
PRESCRIPTION DRUGS	Kaiser Pharmacy	Optum RX	Optum RX
Calendar Year Deductible	N/A	N/A	N/A
Out-of-Pocket Maximum Individual / Family	\$0 / \$0	N/A	Unlimited
Retail Generic Preferred Brand Non-Preferred Brand Specialty Supply limit	\$10 copay \$20 copay \$20 copay \$20 (30-day supply) 100 days	\$10 copay \$20 copay N/A 30-day supply 100 days	\$10 copay + non-Network cost difference \$20 copay + non-Network cost difference N/A Not covered 100 days
Mail Order Generic Preferred Brand Non-Preferred Brand Supply Limit	\$10 copay \$20 copay \$20 copay 100 days	\$10 copay \$20 copay N/A 100 days	\$10 copay + non-Network cost difference \$20 copay + non-Network cost difference N/A Not covered 100 days

¹Deductibles and out-of-pocket maximums accumulate on a calendar year from January 1st, 2025, through December 31st, 2025.

²An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.

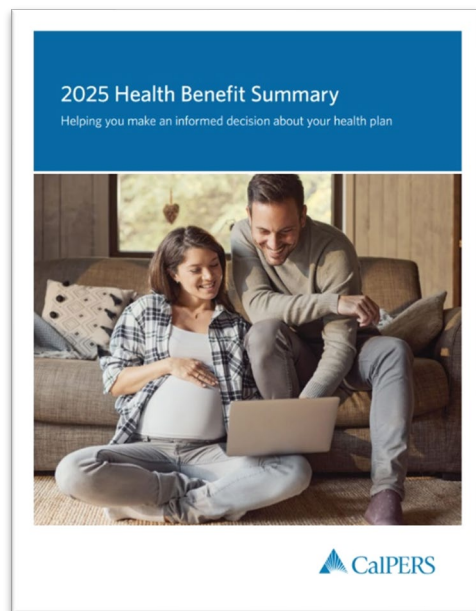
³An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

⁴All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.

⁵After deductible.

⁶Deductible does not apply.

CALPERS MEDICAL BENEFITS – PUBLIC SAFETY EMPLOYEES ONLY



2025 HEALTH BENEFIT SUMMARY

Click the image above to view the 2025 CalPERS Health Benefit Summary.

ENROLLING IN CALPERS PLANS – FOR PUBLIC SAFETY EMPLOYEES

Please make sure to review the enrollment instructions found on the City of Santa Rosa [Benefits webpage](#). All enrollments must be processed through the City of Santa Rosa [BenXcel](#) website, not the CalPERS website.

It is the City of Santa Rosa's goal to provide you with affordable, quality health care benefits. Our medical benefits are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. City of Santa Rosa offers a choice of medical plans through CalPERS Medical for Public Safety employees.

For a summary of the different plans, and additional information please review the CalPERS Open Enrollment site: calpers.ca.gov/page/active-members/health-benefits/open-enrollment. On this site you will find the Health Benefits Summary, Health Program Guide, additional resources and information regarding your CalPERS Health Plan options.

Why would I choose a PPO plan?

- You have a doctor you like, and you would like to keep this doctor.
- You want to see specialists and other providers without having to first get a referral and/or pre-approval.
- You want the freedom to see providers who are not in the network.
- You are confident that you can manage your own care.
- You do not want a primary care doctor.

Why would I choose an EPO plan?

- You want the flexibility to see in-network specialists and other providers without having to first get a referral and/or pre-approval.
- You are confident that you can manage your own care.
- All of your providers are within the EPO network.
- You want more predictable costs than the PPO plan.

Why would I choose an HMO plan?

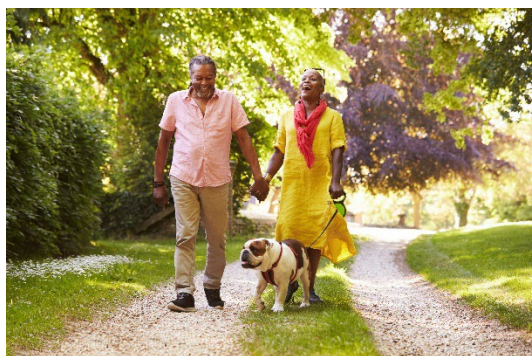
- You don't want the extra responsibility of managing your own care.
- You do not want to pay the higher costs of a PPO.
- You do not want to get bills from providers.

Explore your benefits with myCalPERS

Access your health information year-round, including available health plans and Open Enrollment updates, by logging in to myCalPERS at my.calpers.ca.gov.

To find CalPERS health plans available in your area, search by zip code at calpers.ca.gov.

KAISER RESOURCES



FINDING A KAISER PROVIDER

To find a Kaiser Permanente provider near you, please visit www.kp.org or call (800) 464-4000.

MY HEALTH MANAGER

Stay engaged with your health and simplify your busy life by using the [Kaiser Website](http://www.kp.org) or download the Kaiser Permanente app from the App StoreSM or Google Play[®].

24/7 care advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider at (866) 454-8855.

Kaiser Away From Home

Kaiser Members are covered for emergency and urgent care anywhere in the world. Kaiser's travel [website](#) will explain what to do if you need emergency or urgent care during your trip.

One Pass

The One Pass program offers a variety of features including access to the largest nationwide network of gyms and fitness locations, digital fitness classes, a brain training program, social connection tools, and more. To enroll, visit youronepass.com and register to receive your Member Code. Use your code each time you register for a new fitness facility or One Pass services.

Headspace Care App

The Headspace Care app offers immediate 1-on-1 support for coping with many common challenges — from stress and low mood to issues with work and relationships, and more. Headspace Care's highly trained emotional support coaches are ready to help 24/7, and adult Kaiser Permanente members can use Headspace Care for 90 consecutive days at no cost. Download the app from the App StoreTM or Google Play[®].

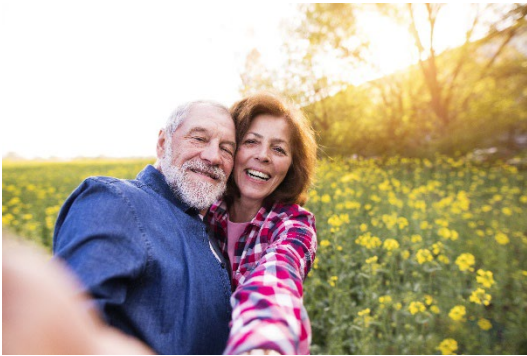
Calm App

The Calm app uses meditation and mindfulness to help lower stress, reduce, anxiety, and improve sleep quality. Adult members can get Calm at kp.org/selfcareapps.

Online wellness tools

Visit kp.org/healthyliving for wellness information, health calculators, fitness videos, podcasts, and recipes from world class chefs. Connect to better health with programs to help you lose weight, quit smoking, and more — all at no cost.

ANTHEM RESOURCES



FINDING AN ANTHEM PROVIDER

To find a provider in the Anthem PPO network, please visit anthem.com/ca/prism/home.

ANTHEM ID CARDS

One ID card will be issued to subscriber and one to spouse/domestic partner. Two cards will be issued in the subscriber's name for subscriber plus child(ren) contracts. ID cards with child dependent names can be requested by calling the member service number on the ID card. Enrollees will also receive an Express Scripts ID card to access pharmacy benefits.

LiveHealth Online

LiveHealth Online is your telemedicine vendor and lets you have a video visit with a board-certified doctor using your smartphone, tablet or computer with a webcam. Doctors are available 24/7/365 to assess your condition and, if it's needed, they can send a prescription to your local pharmacy. Register online and make sure to download the mobile app.

Sydney Mobile App

Use SydneySM Health to keep track of your health and benefits- all in one place. Access your plan details, Member Services, virtual care, and wellness resources. You can also set up an account at anthem.com/ca/register to access most of the same features from your computer.

Building Healthy Families

Building Healthy Families offers personalized, digital support through the SydneySM Health mobile app or on anthem.com/ca. This all-in-one program, at no extra cost to you, can help your family grow strong whether you're trying to conceive, expecting a child, or in the thick of raising young children.

24/7 Nurse Line

24/7 Nurseline serves as your first line of defense for unexpected health issues. You can call a trained, registered nurse to decide what to do about a fever, give you allergy relief tips, or advise you where to go for care.

Concierge Cancer Care Program

The Anthem Concierge Cancer Program provides members with 24/7 guidance, VIP-style cancer care treatment, travel benefits, best-in-class clinical trials in a concierge-style setting and service. Contact the concierge at (888-548-3432).

Rx n' Go

As part of your benefits, employees and dependents on the City Anthem Plans have the option to receive up to a 90-day supply of generic maintenance medication by mail at no cost to you (\$0 copay, \$0 shipping) through a convenient program called, Rx 'n Go.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video



ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Find out more

- [How to create a My SmartCare account](#)
- [List of eligible expenses](#)
- [FSA savings calculator](#)
- [FAQs](#) (log-in required)
- [Claims forms](#)
- [Eligible Expenses](#) – now include more over-the-counter items!
- [IRS Publication 502](#)
- [Ineligible Expenses](#)

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through My SmartCare. For more information on FSA is available at

benefitcc.wealthcareportal.com.

How My SmartCare works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to \$3,300 for the 2025* annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.
- Expenses must be incurred between 01/01/2025 and 12/31/2025 and claims must be submitted for reimbursement no later than 03/31/2025. If you don't spend all the money in your account, you can rollover up to \$660* to use the following year. Any additional remaining balance will be forfeited.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- You must re-enroll in this program each year.

**IRS limits subject to change*

FSA TAX SAVINGS EXAMPLE (SINGLE FILERS)

\$60,000 Annual Pay, with \$1,500 FSA Contribution

\$330	\$115	\$445
22% Federal income tax	7.65% FICA tax	Annual FSA tax savings

\$120,000 Annual Pay, with \$2,850 FSA Contribution

\$684	\$219	\$903
24% Federal income tax	7.65% FICA tax	Annual FSA tax savings

Your tax savings may vary depending on tax filing status and other variables

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA) – MY SMARTCARE RESOURCES



SAVE YOUR RECEIPTS

We recommend saving itemized receipts and EOBs for tax purposes. At the end of the year, My SmartCare will provide you with the tax forms required to file your taxes. You are responsible for reporting your FSA contributions and distributions at tax time.

MY SMARTCARE MOBILE APP

- Check your balance and view account activity
- File a claim and upload documentation in seconds
- Report a card lost or stolen

How to set up and manage your account online

My SmartCare makes it easy for you to manage your FSA with an online account through benefitcc.wealthcareportal.com.

Features of My SmartCare:

- My SmartCare Online Portal
- My SmartCare Mobile APP
- Customer service call center for assistance and questions

How to set up your online account:

1. Go to: benefitcc.wealthcareportal.com/Page/Home
2. Click “Register” at the top right corner of the screen
3. Enter name, zip code, Benefit Account debit card (if applicable), and provide employer ID: **BCCCSR**

Your FSA Debit Card

You will receive your free Debit Card when you enroll in the FSA; mailed directly to your home address. To activate your card, you may call the toll-free number on the activation sticker on the front of your card.

You can use the debit card to pay for eligible services and products. When you use the debit card, payments are automatically withdrawn from your FSA, resulting in fewer out-of-pocket costs for you.

You can also request a debit card for your dependents and/or spouse. A dependent must be 18 years of age or older to receive a debit card in their own name.

How to file a claim if you pay out-of-pocket

If you choose to pay for your FSA eligible expenses out-of-pocket, you can file for a reimbursement.

- Login to your online account or use your mobile app to request a payment be sent directly to your provider or to you.
- Don’t forget about direct deposit! You can set up direct deposit online and allow My SmartCare to deposit reimbursements in your bank account!

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (DFSA)



EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

Dependent Care FSA—up to \$5,000 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by My SmartCare.

Here's how My SmartCare works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to \$5,000 per household per year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Expenses must be incurred between 01/01/2025 and 3/15/2026 (2 ½ month “grace period” after the end of the plan year to incur claims) and claims must be submitted for reimbursement no later than 03/31/2025.



Estimate carefully! You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.



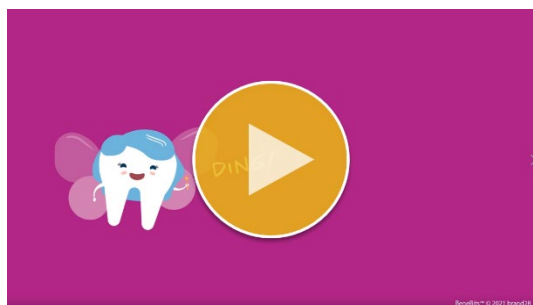
DENTAL

OUR PLANS

DELTA DENTAL BUY UP PLAN (UNIT 8 TRANSIT ONLY)

DELTA DENTAL CORE PLAN (ALL UNITS)

Click to play video



We offer Delta Dental to all units.

The Delta Dental Core Plan is available to all units, and the Delta Dental Buy Up Plan is available to Unit 8 Transit only.

Why Sign Up For Dental Coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers four types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

DELTA DENTAL – ALL UNITS EXCEPT 8

You always pay the deductible and copayment (\$). The coinsurance (%) shows what the plan pays after the deductible.

	Delta Dental DPPO Plan	
	In-Network	Out-of-Network
Calendar Year Deductible Individual / Family	None	None
Calendar Year Maximum Individual	\$2,100	\$2,000 (combined with in-network)
Waiting Period¹	None	None
Diagnostic & Preventive¹	100%	100%
Basic Services¹ Fillings Root Canals Periodontics	80% 80% 80%	80% 80% 80%
Major Services¹	80%	80%
Orthodontia¹ Adults / Children	50%	50%
Ortho Lifetime Max	\$2,000	\$2,000 (combined with in-network)

¹Limitations or waiting periods may apply for some benefits, some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

What you need to know about this plan



Features:

See any provider, but you'll pay more out of network

Am I restricted to in-network providers?

No

Do I have to select a primary dentist?

No

Can I use my FSA?

If you participate in a healthcare FSA, you can use your account to pay for dental expenses.

Where can I get more details?

Please visit www.deltadentalins.com for more information.

DELTA DENTAL CORE AND BUY-UP PLAN – UNIT 8 TRANSIT ONLY

You always pay the deductible and copayment (\$). The coinsurance (%) shows what the plan pays after the deductible.

	DPPO CORE PLAN		DPPO BUY-UP PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible Individual / Family	None	None	None	None
Calendar Year Maximum Individual	\$2,100	\$2,000 (combined with in-network)	\$3,500	\$3,400 (combined with in-network)
Waiting Period	None	None	None	None
Diagnostic & Preventive¹	100%	100%	100%	100%
Basic Services¹ Fillings Root Canals Periodontics	80% 80% 80%	80% 80% 80%	80% 80% 80%	80% 80% 80%
Major Services¹	80%	80%	80%	80%
Orthodontia¹ Adults / Children	50%	50%	50%	50%
Ortho Lifetime Max¹	\$2,000	\$2,000 (combined with in-network)	\$2,000	\$2,000 (combined with in-network)

¹Limitations or waiting periods may apply for some benefits, some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

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Please visit www.deltadentalins.com for more information.

DELTA DENTAL RESOURCES



FINDING A DELTA PROVIDER

To find a Delta Dental provider near you, please visit [deltadentalins.com](https://www.deltadentalins.com) and click "Find a Dentist".

DELTA DENTAL MOBILE APP

Anyone can use Delta Dental Mobile without logging in to access our Find a Dentist and Toothbrush Timer tools, conveniently located on the home screen. You also have the option to save your ID card to the home screen for easy access without logging in. Log into the app to view your personal benefits.

SmileWay® Wellness Benefits

If you or a covered family member have been diagnosed with a chronic medical condition like diabetes, cancer, or rheumatoid arthritis, you have access to 5 cleanings per year. Learn more and opt in by visiting www.deltadentalins.com/smileway, or by calling Customer Service Monday through Friday.

BrushSmart™

A free oral wellness program designed to improve your oral care at home. When you sign up, you will get special offers on great dental brands like Oral-B, Phillips Sonicare, and Quip. Join at brushsmart.org. Fill out the online form to get immediate access to exclusive BrushSmart offers.

Virtual Dentistry

When you can't make it to the dentist's office or have an urgent questions outside of regular hours, you can still get expert dental advice, virtually. Virtual dentistry offers members convenient access to a Delta Dental dentist for answers to questions, quick checkups, second opinions, or other oral health needs in between visits to the dentist's office. Virtual assessments don't count towards exam frequency limitations and are a covered benefit for PPO members. Choose from photo assessments with a 24-hour turnaround for simple dental concerns, or live video visits for immediate care. Visit www1.deltadentalins.com/members/virtual-dentistry.html for more information.

Cost Estimator

Members can plan visits and compare costs before they receive their treatments. Estimates for each member are personalized based on benefits. Members can compare procedure costs at nearby dentists should members need to plan in terms of costs. Members can also receive a detailed explanation of their costs based on upcoming treatment.

Amplifon & Qualsight Discounts

With the Amplifon discount, Delta Dental members get an average savings of 62% off the latest retail hearing aid price. PPO members may even be able to use their plan benefits in coordination with Amplifon discounts. There is also a QualSight discount for Delta Dental members. Members receive 40-50% off the national average price of traditional LASIK eye surgery when you use an experienced QualSight LASIK surgeon.

LifePerks

As a Delta Dental member, you have access to a wide variety of local and national offers and discounts to help you care for your whole body and maintain a healthy life. Register and learn more about LifePerks at discountmember.lifecare.com.



VISION

OUR PLAN

VSP Vision Care

Click play on this video to learn more about how vision plans work, and how to best utilize them!



We offer coverage through VSP Vision Care.

Why Sign Up For Vision Coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

VSP VISION CARE

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	VSP Signature Plan C	
	In-Network	Out-of-Network
Comprehensive Eye Exam Benefit & Materials Frequency	\$20 copay then plan pays 100% Once every 12 months	Up to \$50 Reimbursed In-Network limitations apply
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	\$0 copay Plan pays 100% Plan pays 100% Plan pays 100% Once every 12 months	See schedule below Up to \$50 Up to \$75 Up to \$100 In-Network limitations apply
Frames Benefit Frequency	\$150 Allowance + 20% off over allowance \$170 featured frame brands allowance \$80 Costco frame allowance Once every 12 months	Up to \$70 In-Network limitations apply
Contacts (Elective)* Conventional Medically Necessary Frequency Exam	\$125 Allowance Covered in Full Once every 12 months \$60 copay	Up to \$105 Up to \$210 In-Network limitations apply In-Network limitations apply

*In lieu of frames

What you need to know about this plan



Features:

What other services are covered?

Eyeglasses are expensive. Will I still be able to afford them, even with insurance?

Where can I get more details?

See any provider, but you'll pay more out of network

The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and even hearing aids.

Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in a healthcare FSA, you can use your account to pay for vision care and eyewear with tax-free dollars.

Please visit vsp.com/offers or vsp.com/specialoffers for more information.

VSP SAVINGS AND RESOURCES



ACCESS TO OVER \$3,000 IN EXCLUSIVE MEMBER SAVINGS

Visit vsp.com/offers to learn more about these resources and other VSP exclusive member extras.

Extra Savings on Glasses and Sunglasses

Get an extra \$20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. You can also save 30% on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.

Retinal Screening

You won't pay more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam.

LASIK - Laser Vision Correction

Save up to an average of 15% off the regular price of LASIK or 5% off the promotional price. Discounts are only available from contracted facilities. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

TruHearing® Hearing Aid Discount

VSP® Vision Care members can save up to 60% on a pair of hearing aids with TruHearing. What's more, your dependents and even extended family members are eligible, too.

TruHearing also provides members with:

- 3 provider visits for fitting, adjustments, and cleanings
- A 45-day trial
- 3-year manufacturer's warranty for repairs and one-time loss and damage
- 48 free batteries per hearing aid

Learn more about this VSP Exclusive Member Extra at truhearing.com/vsp or call (877)396-7194.

VSP Diabetic Eyecare Plus Program

This program provides coverage of additional eyecare services specifically for members with diabetic eye disease, glaucoma or age-related macular degeneration (AMD). Eligible members can receive both routine and follow-up medical eyecare from their VSP doctor—the doctor who already knows their eyes best.

The program also provides supplemental coverage for non-surgical medical eye conditions such as diabetic retinopathy, abnormal blood vessel growth on the eye (rubeosis), and diabetic macular edema. Members can self-refer, visit their VSP Provider as often as needed, and pay only a copay for services.



LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes. Beneficiary changes can be made online via benefitcc.wealthcareportal.com.

Is your family protected?

Life, AD&D, Short-Term and Long-Term disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide short and long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

If you need additional coverage

We offer voluntary coverage that you can purchase for yourself and your spouse.

CITY PROVIDED LIFE AND AD&D INSURANCE



A NOTE ABOUT TAXES

Company-provided life insurance coverage over \$50,000 is considered a taxable benefit. The value of the benefit over \$50,000 will be reported as taxable income on your annual W-2 form.

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by Lincoln Financial, and premiums are paid in full by the City of Santa Rosa.

Class Definition

- Unit 2 (Firefighters) – Class 2
- Unit 3 (Maintenance) – Class 3
- Unit 4 (Support Services) – Class 3
- Unit 5 (Police Officers) – Class 1
- Unit 6 (Professional) – Class 3
- Unit 7 (Technical) – Class 3
- Unit 8 (Transit) – Class 3
- Unit 9 (Public Safety Management) – Class 4
- Unit 10 (Executive Management) – Class 6
- Unit 10s (Safety Executive Management) – Class 6
- Unit 11 (Confidential Mid-Management) – Class 6
- Unit 12 (Confidential) – Class 6
- Unit 13 (Mechanics) – Class 3
- Unit 14 (Police Civilian Technical) – Class 5
- Unit 15 (City Appointed Officials) – Class 7
- Unit 16 (Utilities Systems Operators) – Class 3
- Unit 17 (Professional Attorneys) – Class 6
- Unit 18 (Mid-Management) – Class 6
- Unit 99 (Elected Officials) – Class 6

Basic Life Coverage Amount

- Class 1 – \$10,000
- Class 2 – \$12,000
- Class 3 – \$20,000
- Class 4 – \$30,000
- Class 5, 6 – \$50,000
- Class 7 – \$250,000

Basic AD&D Coverage Amount

Class 4, 6, 7

For a covered accidental loss of life, your Basic AD&D coverage amount is equal to your Basic Life coverage amount. For other covered losses, a percentage of this benefit will be payable.

Class 1, 2, 3, 5
Not available

VOLUNTARY LIFE AND AD&D INSURANCE



EVIDENCE OF INSURABILITY (EOI)

If you elect Voluntary Life coverage above guaranteed issue (noted on this page), or if you are a late entrant (enrolling more than 31 days after the date you become eligible), you must complete and submit EOI. This can be completed online through your enrollment process via <https://benxcel.net/>.

Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Lincoln Financial and available for you and your spouse. All employees can select up to \$300,000 at hire without providing proof of good health if the application is made within 31 calendar days of their new hire date or qualifying event but may select coverage up to \$500,000.

Lincoln Financial Voluntary Life

Employee	Increments of \$10,000 up to \$500,000 Guaranteed Issue: \$300,000
Spouse	Increments of \$10,000 up to \$50,000 Guaranteed Issue: \$20,000
Children	Not available

Note: Benefit amount for employees only, reduces to 65% at age 65 through 69 and to 50% at age 70 or over.

In the event of a serious or fatal accident

Voluntary AD&D Insurance allows you to purchase accidental death and dismemberment coverage that pays your beneficiary if you have a fatal accident. If you experience a serious injury such as a loss of a limb, speech, sight or hearing, the plan pays a benefit to you.

Coverage is provided by Lincoln Financial and is available for you and your spouse.

Lincoln Financial Voluntary AD&D

Employee	Increments of \$10,000 up to \$500,000
Spouse	Increments of \$10,000 up to \$50,000
Children	Not available

SHORT-TERM DISABILITY INSURANCE (STD)



EXPECT THE UNEXPECTED

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

SUBMITTING A CLAIM

If you are disabled due to an illness or accidental injury, unable to work, and under the care of a licensed physician, you are eligible to submit a claim for benefits under this plan. As long as you remain disabled and meet the plan’s disability requirements, you will continue to receive a percentage of your earnings until benefits are no longer payable.

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as workers' compensation, Social Security, or state disability. The City of Santa Rosa pays the cost of this coverage. Coverage is provided by Lincoln Financial.

Class 1	Units 2, 3, 4, 5, 6, 7, 8, 9F, 9P, 10, 10S, 11, 12, 13, 14, 15, 16, 17, 18, & 99
Weekly Benefit Amount	Plan pays 55% of the first \$2,727 of weekly pre-disability earnings, reduced by deductible income up to \$1,500
Maximum Weekly Benefit	\$1,500
Benefits Begin After	
Accident	7 days of disability
Sickness	7 days of disability
Maximum Payment Period¹	60 days

¹Maximum payment period is based on the first day benefits begin, not the first day you are disabled.

LONG-TERM DISABILITY INSURANCE (LTD)



4 THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.
4. Benefits are tax-free, since you pay the premiums with after-tax dollars.

LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. The City of Santa Rosa pays the cost of this coverage. Coverage is provided by Lincoln Financial.

Lincoln Financial LTD Plan

Class 1	Units 4, 6, 7, 10, 10S, 11, 12, 15, 17, 18, & 99			
Class 2	Units 8			
Class 3	Units 3, 13, & 16			
Class 4	Units 14			
Non-Eligible Units	Units 2, 5, 9F, & 9P			
	Class 1	Class 2	Class 3	Class 4
Elimination / Waiting Period³	60 Days			
Maximum Monthly Benefit	\$6,000	\$5,000	\$5,000	\$5,000
Minimum Monthly Benefit	\$100	\$100	\$100	\$100
Maximum Payment Period¹	SSNRA ²	SSNRA ²	SSNRA ²	SSNRA ²

¹The age at which the disability begins may affect the duration of the benefits.

²Social Security Normal Retirement Age.

³Benefits begin after the end of your short-term disability, or a period of 60 days of disability, whichever is greater. Leave balances must also be exhausted.

LINCOLN PAID FAMILY LEAVE



LINCOLN FINANCIAL PORTAL

Employees can easily report a (PFL) claim and check its status through LincolnFinancial.com. First time users will enter Company Code **LF1572CIT**. You may also call (888) 408-7300 to report a claim.

Paid Family Leave (PFL) Benefit

Paid Family Leave (PFL) insurance is available through Lincoln Financial Group for all units that are covered under Short Term Disability (STD).

PFL provides income protection when you take time off by replacing part of your income for limited duration issues such as:

- A serious health condition
- Bonding with newly born minor child, adopted or fostered child
- Taking care of a seriously ill family member
- Participating in a qualifying military event

Class 1	Units 2, 3, 4, 5, 6, 7, 8, 9F, 9P, 10, 10S, 11, 12, 13, 14, 15, 16, 17, 18, & 99
Weekly Benefit Amount	Plan pays 60%-70% of your base weekly salary*
Maximum Weekly Benefit	\$1,620
Maximum Benefit Duration	Up to 8 weeks within a calendar year

*Based on highest quarter of base period.

Benefit Highlights

- Provides cash benefits when you need it most
- Works as an income substitute up to the maximum benefit duration on a continuous and/or intermittent basis within a 12-month period
- Benefits begin on first day of leave
- Convenient claims process

LINCOLN FINANCIAL VALUE-ADDED SERVICES



WellnessPATH®

Lincoln WellnessPATH® provides tools and personalized steps to manage your financial life. From creating a budget to building an emergency fund to paying down debt, this easy-to-use online tool helps you turn information into action so you can focus on both short- and long-term goals, like saving for retirement. Contact your Human Resources contact to start using Lincoln WellnessPATH® today.

TravelConnect® Services

TravelConnect® services provide a wealth of medical, safety and travel-related services you can access while on a business or leisure trip more than 100 miles from home. It includes evacuation services, Travel Assistance services, and medical, dental and pharmacy referrals. To access, call collect from anywhere in the world: +1(603) 328-1955 or Toll Free from US or Canada: (866) 525-1955.

LifeKeys® Services

This program provides access to a wide array of services to help you and your loved ones through life's ups and downs — and prepare you for whatever lies ahead. Services include online will preparation, access to GuidanceResources® Online, protection against identity theft, and guidance and support for your beneficiaries. It's easy to access LifeKeys® services. Just call (888) 628-4824 or visit [GuidanceResources.com](https://www.guidanceresources.com). (First-time user: Enter Web ID LifeKeys).

FuneralPrep

Funeral planning through Lincoln Financial Group offers both pre-planning and at-need services at or near the time of need. You can access FuneralPrep by visiting the self-service online portal at [LincolnFuneralPrep.com/GPLife](https://lincolnfunderalprep.com/GPLife) or by connecting with a funeral planning consultant.

EmployeeConnectSM

EmployeeConnectSM offers professional, confidential services for both you and your loved ones. Receive up to 5 face-to-face counseling visits and one free 30-minute in person consultation per legal issue. It includes unlimited phone access 24/7 and web access to helpful articles, resources, and self-assessment tools. To access call or visit [GuidanceResources.com](https://www.guidanceresources.com). (888) 628-4824

- Username: LFGSupport
- Password: LFGSupport1



WELLBEING & BALANCE

THE KEY TO KEEPING YOUR BALANCE IS KNOWING WHEN YOU'VE LOST IT

The challenges of daily life can be hard to balance. Whether it's work, school or family obligations, it's no wonder that many of us sometimes have trouble managing the ups and downs of our day-to-day lives.

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, chemical dependency, mental health and family issues
- Maximize your physical well-being
- Take time to spend with family and friends
- Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

CONCERN - EMPLOYEE ASSISTANCE PROGRAM (EAP)



CONTACT THE EAP

Phone:

800-344-4222

Website:

employees.concernhealth.com

Company code: **SANTAROSA**

Online Sources:

[Online Therapy with BetterHelp
Resilience Hub™](#)

[Life Adviser](#)

eM Life

Concern has partnered with **eMindful** to provide access to an entire suite of evidenced-based live and on-demand mindfulness solutions.

To log-in, visit:

app.concernhealth.com/sso/emindful.

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Concern can help you handle a wide variety of personal issues such as emotional health and substance abuse; parenting and childcare needs; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 10 sessions per issue per member
- Unlimited web access to helpful articles, resources, and self-assessment tools

COUNSELING BENEFITS

- Difficulty with relationships
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

FINANCIAL COACHING

- Money management
- Debt management
- Identity theft resolution
- Tax issues

LEGAL CONSULTATION

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

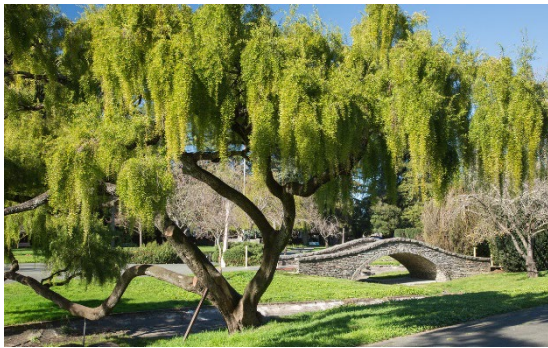
ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

TEAMSTERS ASSISTANCE PROGRAM (TAP)



HOW TO CONTACT TAP

Phone: 800-253-8326

TAP is a program established to provide assessment and referral for treatment of substance abuse problems for employees enrolled in a Teamsters medical plan. In addition, TAP counselors are available to provide short-term problem focused assessment sessions regarding work, personal, family and marital issues.

Substance Abuse Testing

Tap counselors will either schedule an appointment for you or your Dependent or direct you to the most appropriate health care professional in their pre-screened network for additional assistance or treatment. TAP counselor(s) advocate on behalf of the participant to help provide the recommended level of care. TAP Counselor(s) monitor the participant's progress while in treatment and provide post-treatment follow-up and referral to TAP's two-year continuing care program. Participants are eligible to participate in TAP's monthly sobriety celebrations, Alumni Association activities and support services.

After you or your Dependent has met the annual medical plan deductible the Plan covers TAP providers as any other PPO provider, and non-TAP providers as any other non-PPO provider.

Employee Assistance

TAP is also a confidential assessment and referral counseling service for you and your dependents who have concerns or problems that are affecting your work or home life. The program provides help with things like:

- Personal / emotional problems
- Stress related issues
- Marital / family issues
- Financial problems
- School-related problems your children are experiencing
- An aging parent

Participants in an HMO Medical Plan

If you are covered under Kaiser HMO plan offered by the Fund, TAP counselor (s) will utilize available substance abuse benefits available from your medical plan.

WELLNESS PROGRAM

Enhance your well-being

Being well involves more than just using your healthcare plans. Wellness is a daily commitment to eating healthy, staying active, managing stress and maintaining balance. With this in mind, we've created an integrated wellness program, to help you create healthy habits and reach your highest level of well-being.

The program consists of support for managing stress, choosing nutritious foods, staying active, maintaining or reaching a healthy weight, avoiding unhealthy habits, and more.

Wellness annual payment

In recognition of the importance of a healthy workforce and to promote physical and mental fitness for staff, the City sponsors an employee wellness program. To promote health and wellness, including employees' physical and mental fitness, the program consists of an annual payment to each employee of \$500 on the first paycheck in January of each year. The payment can be used for wellness programs such as gym memberships, fitness equipment, and/or weight loss programs which will enhance the health and wellbeing of City staff. Employees should keep documentation for the program as verification and receipts may be requested.





FINANCIAL WELLNESS

PLANS TO HELP YOU SAVE

Transportation & City Bus
457(b) Deferred Compensation
Roth 457 Plan

Is it time for a “financial wellness” checkup?

Are you worried about money—making your paycheck last?
Paying down debt? Making a big purchase like a car or home?
And can you even think about preparing for retirement?

Ignoring your financial health can take a toll on your quality of life today and block opportunities for the future. And worrying about money matters can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money now and in the future. You can increase your take-home pay by saving on taxes and work towards your retirement goals.

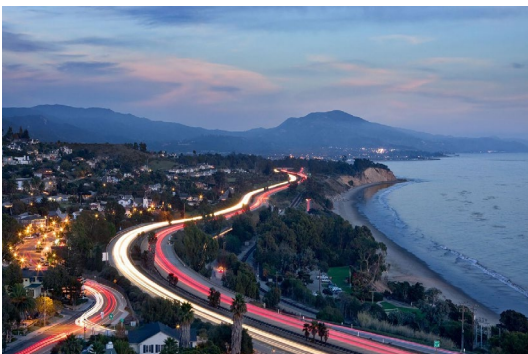
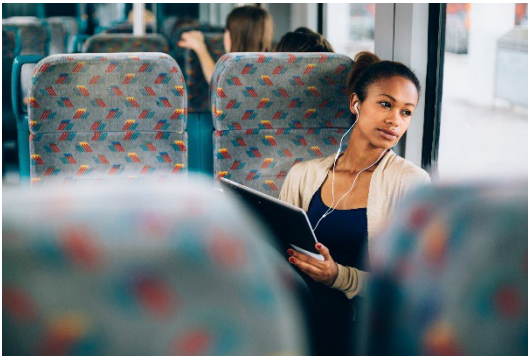
SAVE ON COMMUTE EXPENSES

Welcome to Transit and CityBus

In addition to many benefits of working for the City of Santa Rosa, you can now ride the Santa Rosa City Bus, on any route, at any time, free of charge, with your City issued identification card. Just show your I.D. card to the bus operator when you board.

For your convenience, a Santa Rosa City Bus System Map, with time schedules, is included in your new employee information packet. You will also find our online trip planning program a great tool for planning any of your Santa Rosa City bus trips. Check it out at www.srcity.org/citybus.

Also online, you'll find a brochure describing our Learn to Ride the City Bus Travel Training Program and a brochure that explains the benefits of our Trip Reduction Incentive Program – Santa Rosa Free Ride.



How to contact?

If you have any questions or would like additional information, please stop by the Transit Operations Building at 45 Stony Point Road, our Customer Service Kiosk at the Transit Mall downtown (2nd St between Santa Rosa Ave. and B St) or contact us at tptellus@srcity.or or at extension 3333.

457 (b) DEFERRED COMPENSATION



WANT MORE INFORMATION?

Please [schedule an appointment](#) with **MissionSquare** representative, Kim Hammond, or call her at (866) 265-5964.

Please [schedule an appointment](#) with **Nationwide** representative, Lauren Ryan, or call her at (805) 252-3193.

457 Plan

Deferred Compensation permits full-time and permanent part-time employees (working 20 or more hours per week), on a voluntary basis, to authorize a portion of salary to be withheld and invested for payment at a later date upon termination or retirement. You have two enrollment options, the Traditional 457 Plan and the Roth 457 Plan.

Traditional 457 Plan

With the Traditional 457 Plan, neither the deferred amount nor earnings on the investments are subject to current federal or state income taxes. Taxes become payable when deferred income plus earnings are distributed, presumably during retirement when you are in a lower income tax bracket.

Roth 457 Plan

The Roth 457 Plan provides an alternative to pre-tax investing. Roth contributions are considered “after-tax,” which means taxes are withheld when you contribute. However, qualified distributions on your contributions plus any earnings are completely tax-free.

For example, if you contribute \$100, the entire \$100 comes out of your net pay, but when you make eligible withdrawals from your account, the entire amount plus any earnings are entirely tax-free

Contribution Limits

Employees age 50 or older may contribute up to \$7,500 for a total of \$30,000.

The normal contribution limit for the 457 plan is \$22,500.



IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your benefit contributions
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify the City of Santa Rosa, if your domestic partner is your tax dependent.

2025 CITY HEALTH MEDICAL PLAN RATES

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

	Kaiser HMO			Anthem EPO			Anthem PPO		
Full-Time Employees	Total Monthly Premium	Monthly Employee Payment (15% of total monthly premium)	Semi-Monthly EE Paycheck Deduction	Total Monthly Premium	Monthly Employee Payment (20% of total monthly premium)	Semi-Monthly EE Paycheck Deduction	Total Monthly Premium	Monthly Employee Payment (12.5% of total monthly premium)	Semi-Monthly EE Paycheck Deduction
Single	\$888.00	\$133.20	\$66.60	\$957.00	\$191.40	\$95.70	\$830.00	\$103.74	\$51.87
Double	\$1,800.00	\$270.00	\$135.00	\$1,945.00	\$389.00	\$194.50	\$1,683.00	\$210.36	\$105.18
Family	\$2,511.00	\$376.64	\$188.32	\$2,718.00	\$543.60	\$271.80	\$2,364.00	\$295.50	\$147.75
	Kaiser HMO			Anthem EPO			Anthem PPO		
Part-Time Employees	Total Monthly Premium	%FTE	Semi-Monthly EE Paycheck Deduction	Total Monthly Premium	%FTE	Semi-Monthly EE Paycheck Deduction	Total Monthly Premium	%FTE	Semi-Monthly EE Paycheck Deduction
Single	\$888.00	50%	\$255.30	\$957.00	50%	\$287.10	\$830.00	50%	\$233.43
		60%	\$217.56		60%	\$248.82		60%	\$197.12
		75%	\$160.95		75%	\$191.40		75%	\$142.65
		80%	\$142.08		80%	\$172.26		80%	\$124.49
		85%	\$123.21		85%	\$153.12		85%	\$106.33
		90%	\$104.34		90%	\$133.98		90%	\$88.18
		95%	\$85.47		95%	\$114.84		95%	\$70.02
Double	\$1,800.00	50%	\$517.50	\$1,945.00	50%	\$583.50	\$1,683.00	50%	\$473.34
		60%	\$441.00		60%	\$505.70		60%	\$399.70
		75%	\$326.25		75%	\$389.00		75%	\$289.26
		80%	\$288.00		80%	\$350.10		80%	\$252.44
		85%	\$249.75		85%	\$311.20		85%	\$215.62
		90%	\$211.50		90%	\$272.30		90%	\$178.81
		95%	\$173.25		95%	\$233.40		95%	\$141.99
Family	\$2,511.00	50%	\$721.91	\$2,718.00	50%	\$815.40	\$2,364.00	50%	\$664.87
		60%	\$615.19		60%	\$706.68		60%	\$561.45
		75%	\$455.11		75%	\$543.60		75%	\$406.31
		80%	\$401.75		80%	\$489.24		80%	\$354.60
		85%	\$348.39		85%	\$434.88		85%	\$302.88
		90%	\$295.03		90%	\$380.52		90%	\$251.17
		95%	\$241.67		95%	\$326.16		95%	\$199.46

YOUR 2025 TEAMSTERS MEDICAL PLAN RATES

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

	Kaiser HMO			Anthem EPO (Grandfathered employees only)			Anthem PPO		
Full-Time Employees	Total Monthly Premium	Monthly Employee Payment (12.5% of total monthly premium)	Semi-Monthly EE Paycheck Deduction	Total Monthly Premium	Monthly Employee Payment (20% of total monthly premium)	Semi-Monthly EE Paycheck Deduction	Total Monthly Premium	Monthly Employee Payment (12.5% of total monthly premium)	Semi-Monthly EE Paycheck Deduction
Single	\$969.55	\$121.18	\$60.59	\$1,307.60	\$261.52	\$130.76	\$991.28	\$123.90	\$61.95
Double	\$1,873.10	\$234.12	\$117.06	\$2,661.30	\$532.26	\$266.13	\$1,989.16	\$248.64	\$124.32
Family	\$2,623.04	\$327.88	\$163.94	\$3,769.01	\$753.80	\$376.90	\$2,782.50	\$347.80	\$173.90
	Kaiser HMO			Anthem EPO			Anthem PPO		
Part-Time Employees	Total Monthly Premium	%FTE	Semi-Monthly EE Paycheck Deduction	Total Monthly Premium	%FTE	Semi-Monthly EE Paycheck Deduction	Total Monthly Premium	%FTE	Semi-Monthly EE Paycheck Deduction
Single	\$969.55	50%	\$272.68	\$1,307.60	50%	\$392.28	\$991.28	50%	\$278.79
		60%	\$230.26		60%	\$339.97		60%	\$235.42
		75%	\$166.63		75%	\$261.52		75%	\$170.37
		80%	\$145.42		80%	\$235.36		80%	\$148.68
		85%	\$124.21		85%	\$183.06		85%	\$127.00
		90%	\$103.00		90%	\$156.91		90%	\$105.31
		95%	\$81.79		95%	\$392.28		95%	\$83.63
Double	\$1,873.10	50%	\$526.80	\$2,661.30	50%	\$798.39	\$1,989.16	50%	\$559.45
		60%	\$444.85		60%	\$691.93		60%	\$472.42
		75%	\$321.93		75%	\$532.26		75%	\$341.88
		80%	\$280.95		80%	\$479.03		80%	\$298.37
		85%	\$239.98		85%	\$372.58		85%	\$254.85
		90%	\$199.00		90%	\$319.35		90%	\$211.34
		95%	\$158.03		95%	\$798.39		95%	\$167.83
Family	\$2,623.04	50%	\$737.73	\$3,769.01	50%	\$1,130.70	\$2,782.50	50%	\$782.57
		60%	\$622.97		60%	\$979.94		60%	\$660.84
		75%	\$450.83		75%	\$753.80		75%	\$478.23
		80%	\$393.45		80%	\$678.42		80%	\$417.37
		85%	\$336.07		85%	\$527.66		85%	\$356.50
		90%	\$278.69		90%	\$452.28		90%	\$295.63
		95%	\$221.31		95%	\$1,130.70		95%	\$234.76

YOUR BENEFIT COSTS FOR DENTAL AND VISION

Miscellaneous Employees (NOT INCLUDING UNIT 8 – TRANSIT)

Dental/ Vision Plan (Plan C) Rates for Units 3, 4, 6, 7, 10-14, 15-18, & 99

FOR FULL-TIME EMPLOYEES ONLY

	Total Monthly Premium	Employee Contribution Semi-Monthly
Single	\$73.31	\$0.00
Double	\$124.48	\$0.00
Family	\$176.72	\$0.00

Unit 8 – Transit Employees only

Dental CORE & BUY-UP Option / Vision Plan (Plan C) Rates

	Total Monthly Premium CORE Plan	Employee Contribution Semi-monthly CORE Plan	Total Monthly Premium BUY-UP Plan	Employee Contribution Semi-Monthly
Single	\$79.31	\$0.00	\$96.31	\$0.00
Double	\$135.48	\$0.00	\$165.48	\$8.00
Family	\$191.72	\$0.00	\$233.72	\$16.00

Safety Employees

Dental/ Vision Plan (Plan C) Rates for Units 2, 5 & 9

	Total Monthly Premium	Employee Contribution Semi-Monthly
Single	\$73.31	\$1.83
Double	\$124.48	\$3.11
Family	\$176.72	\$4.41

For Part-time rates, please contact your HR department.

PLAN CONTACTS

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

Carrier	Claims Address	Phone Number	Website	Policy No.
BCC My Smart Care (FSA)	BCC, Attn: Claims Tow Robinson Plaza, Suite 200 Pittsburgh, PA 15205	(800) 685-6100	CustomerSupport@benxcel.com	N/A
CalPERS	N/A	(888) 225-7377	calpers.ca.gov	N/A
CalPERS Medical		See website	https://www.calpers.ca.gov/page/active-members/health-benefits/plans-and-rates	
City Plans Anthem Blue Cross Medical	2 Embarcadero Center San Francisco, CA 94111	(800) 333-0912	www.anthem.com/ca/prism	EPO:175075M717 PPO:175075M709 Green:175075M721
City Plans Express Scripts RX (for City Anthem plans)	PO Box 52150 Phoenix, AZ 85072	Members: (877) 733-4553 Medicare Members: (844) 468-0428	www.express-scripts.com	EPO:175075M717 PPO:175075M709
City Plans Rx 'n Go RX (for City Anthem plans)	Rx n' Go c/o Transition Pharmacy 2546 Metropolitan Dr Trevose, PA 19053	(888) 697-9646	www.rxngo.com	1336325265
City Plans Kaiser Permanente Medical & RX	Administration Department P.O. Box 7004 Downey, CA 90242	(800) 464-4000	www.kp.org	8961
City of Santa Rosa HR Benefits		(707) 543-3060 Email: benefits@srcity.org		
Concern EAP	Santa Rosa	(800) 344-4222	Employees.comcernhealth.com	SantaRosa
Deferred Compensation MissionSquare Kim Hammond	hammondk@icmarc.org	(866) 265-5964	www.icmarc.org	
Deferred Compensation Nationwide Lauren Ryan	Paul.menard@nationwide.com	(805) 252-3193	www.nationaldeferred.com	
Delta Dental	100 1st St #400 San Francisco, CA 94105	(800) 765-6003	www.deltadentalins.com	Unit 8 only: 3066-01002 All other Units: 3066-0015
Lincoln Financial	PO Box 2578 Omaha, NE 68172-9688	(877) 275-5462	www.lincolfinancial.com Company Code: LF1572CIT	09-LF1572
Northwest Administrative (Teamsters Medical)	N/A	(800) 297-4595	www.nwadmin.com	N/A
Teamsters Anthem	PO Box 60007 Los Angeles, CA 90060	(800) 688-3828	www.anthem.com/ca	EPO: 856-ME30 PPO: 856-MB30
Teamsters Optum RX (for Anthem PPO members)	PO Box 29046 Hot Springs, AR 71903	(800) 797-9791	www.optumrx.com	BIN: 610494 PCN: 999 Group:856
Teamsters Kaiser HMO	Administration Department P.O. Box 7004 Downey, CA 90242	(800) 464-4000	www.kp.org	7038-10
Travel Assistance (AssistAmerica)	N/A	(800) 872-1414 (US, CAN, PR etc) (609) 98612344 (Everywhere else)	medservices@assistamerica.com	01-AA-STD-5201
VSP Vision	N/A	(800) 877-7195	www.vsp.com	101620

GLOSSARY

-A-

AD&D Insurance

An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount

The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)

A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit

A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing

In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is \$100 but the plan's allowable charge is only \$70, an out-of-network provider may bill YOU for the \$30 difference (the balance).

Beneficiary

The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug

A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA

A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim

A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance

Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment

A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible

The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an **aggregate** or **embedded** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services

Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services

Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)

An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age

13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense

A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service

A service that your health plan doesn't pay for or cover.

-F-

Formulary

A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug

A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered

A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)

A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network

In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance

An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance

Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order

A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment

The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network

Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of-network services at all.

Out-of-Pocket Cost

A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum

Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care

Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy

A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year

A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug

Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services

Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)

The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance

Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc

A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care

Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations

Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit

An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document, located at the end of this guide:

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **Availability of Privacy Practices Notice**
- **Notice of Choice of Providers:** Notifies you that your plan requires you to name a Primary Care Physician (PCP) or provides for you to select one
- **Michelle's Law:** Describes right to extend dependent medical coverage during student leaves
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

DEADLINE FOR FILING LAWSUIT UNDER ERISA AFTER EXHAUSTION OF ALL CLAIMS PROCEDURES

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan specific statute of limitations.

Medicare Part D Notice

Important Notice from the City of Santa Rosa About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The City of Santa Rosa and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
 2. The City of Santa Rosa has determined that the prescription drug coverage offered by the health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
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When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your City of Santa Rosa coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

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

If you do decide to join a Medicare drug plan and drop your City of Santa Rosa prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Santa Rosa and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

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

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

- Visit [medicare.gov](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [socialsecurity.gov](https://www.socialsecurity.gov), or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2025
Name of Entity/Sender:	The City of Santa Rosa
Contact-Position/Office:	Human Resources
Address:	100 Santa Rosa Avenue, Room #1 Santa Rosa, CA 95404
Phone Number:	(707) 543-3060

Women's Health and Cancer Rights Act

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. If you would like more information on WHCRA benefits, call your plan administrator.

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). If you would like more information on maternity benefits, call your plan administrator.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in City of Santa Rosa health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in City of Santa Rosa health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in City of Santa Rosa's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for the City of Santa Rosa describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting the Human Resources Department.

Notice of Choice of Providers

Your health plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your health plan directly.

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

You do not need prior authorization from your health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health plan.

Michelle's Law

The health plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify Human Resources as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.02% in 2025 of your modified adjusted household income.

MODEL COBRA NOTICE

General Notice Of COBRA Continuation Coverage Rights (For use by single-employer group health plans) ** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under City of Santa Rosa's City health plans (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review your Plan's Summary Plan Description (SPD) or contact City of Santa Rosa's HR Benefits. You can access copies of the City's plans' SPDs at <https://flimp.live/CityofSantaRosa>.

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information: must pay or aren't required to pay*] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of **July 31, 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.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, press 2

INDIANA – Medicaid
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: (800) 403-0864 Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) 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: 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/health-care-coverage/ Phone: 1-800-657-3672
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: HSHIPPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
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
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 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 Rlte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services
Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access
Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/
Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

Notes

