2024 RETIREE BENEFITS

CITY OF PITTSBURG

BENEFITS IN FOCUS

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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.

GETTING STARTED

2024 BENEFITS
January 1, 2024
through
December 31, 2024

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, City of Pittsburg supports 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 medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

CITY OF PITTSBURG COBRA PLAN RATES

Medical COBRA rates for 2024 COBRA Coverage includes 2%			
Active Employees	Kaiser	Anthem EPO	Anthem PPO
Single	945.29	1270.25	962.96
Dual	1823.25	2585.26	1932.63
Family	2551.97	3661.33	2703.00

Dental, Vision and EAP COBRA rates for 2024 COBRA Coverage includes 2%				
Active Employees	Dental (non AFSCME)	Dental (AFSCME)	EAP	VSP Vision
Single	51.00	53.86	4.13	14.38
Dual	94.35	99.76	4.13	14.38
Family	162.79	172.38	4.13	14.38

CITY OF PITTSBURG RETIREE MEDICAL PLAN RATES

Retiree Medical	Kaiser	Anthem EPO	Anthem PPO	United Health HMO	Health Net Sr+
Early Retiree Single	926.75	1245.34	944.08		
Early Retiree Dual	1787.50	2534.57	1894.74		
Early Retiree Family	2501.93	3589.54	2650.00		
One Early Retiree & One Medicare - Sr. Adv/Supp	1252.18		1488.50		
Single Medicare - Sr. Adv/ UHC/Sr+	350.43			495.42	615.03
Single Medicare - Supplement			569.42		
Dual Medicare - Sr. Adv/UHC/Sr+	700.86			990.84	1230.06
One Early Retiree, One Medicare - Sr. Adv/Supp, & Dependent(s)	2112.93		3194.42		
Dual Medicare - Supplement			1138.84		

MEDICAL

OUR PLANS

HEALTH NET - HMO

ANTHEM EPO

ANTHEM PPO

KAISER SENIOR ADVANTAGE PLAN – KPSA

UNITED HEALTHCARE - HMO

All About Medical Plans

We offer medical plans through Health Net, Anthem Blue Cross, Kaiser Permanente, and United Healthcare. Review the network provider information and out-of-pocket costs such as deductible, coinsurance and prescription drugs so you can choose the best fit for your health concerns and budget.

Which Plan Is Right For You?

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

Consider a PPO (Preferred Provider Organization) if:

- You want to be able to see any provider, even a specialist, without a referral
- You are willing to pay more to see out-of-network providers

Consider an HMO (Health Maintenance Organization) or an EPO (Exclusive Provider Organization) if:

- You want lower, predictable out-of-pocket costs
- You like having one doctor to manage your care
- You are happy with the selection of network providers
- You don't see any doctors that are out-of-network
- You have convenient access to Kaiser facilities

ANTHEM MEDICAL PLANS – EPO & PPO

Here is an overview of our medical plans offered through Anthem Blue Cross.

	Anthem EPO (Closed to new enrollment)	Anthem PPO	
	In-Network	In-Network	Out-Of-Network
Annual Deductible	$0 per individual $0 family limit	$250 per individual $500 family limit	$250 per individual (combined with in-network) $500 family limit (combined with in-network)
Annual Out-of-Pocket Max	$2,000 per individual $3,000 family limit	$2,000 per individual	Not applicable Not applicable
Lifetime Max	Unlimited	Unlimited	Unlimited
Office Visit			
Primary Provider	$15 copay then plan pays 100%	$20 copay then plan pays 100%	plan pays 60% after deductible
Specialist	$15 copay then plan pays 100%	$20 copay then plan pays 100%	plan pays 60% after deductible
Preventive Services	Plan pays 100%	plan pays 100%	Not covered
Chiropractic Care	$15 copay then plan pays 100% (combined acupuncture limit: up to 20 visits per year)	plan pays 80% after deductible (up to 40 visits per year)	plan pays 60% after deductible (in-network limitations apply)
Lab and X-ray	plan pays 100%	plan pays 80% after deductible	plan pays 60% after deductible
Inpatient Hospitalization	plan pays 100%	Plan pays 80% after deductible	plan pays 50% after deductible
Outpatient Surgery	plan pays 100%	plan pays 80% after deductible	plan pays 50% after deductible
Urgent Care	$15 copay then plan pays 100%	plan pays 80% after deductible	plan pays 50% after deductible
Emergency Room	$50 copay then plan pays 100% (copay waived if admitted)	plan pays 80% after deductible	plan pays 80% after deductible

ANTHEM PRESCRIPTION DRUG PLANS - EPO & PPO

Below is the prescription drug plans that are offered with our Anthem Blue Cross plans.

	Anthem EPO (Closed to new enrollment)	Anthem Rx PPO	
	In-Network	**In-Network**	**Out-Of-Network**
Annual Out-of-Pocket Limit	Prescriptions subject to medical out-of-pocket maximums	Prescriptions subject to medical out-of-pocket maximums	Prescriptions subject to medical out-of-pocket maximums
Pharmacy			
Generic	$10 copay then plan pays 100%	$10 copay then plan pays 100%	$10 copay then plan pays 100%
Preferred Brand	$20 copay then plan pays 100%	$20 copay then plan pays 100%	$20 copay then plan pays 100%
Non-preferred Brand	Not covered	Not covered	Not covered
Supply Limit	100 days	100 days	100 days
Mail Order			
Generic	$10 copay then plan pays 100%	$10 copay then plan pays 100%	$10 copay then plan pays 100%
Preferred Brand	$20 copay then plan pays 100%	$20 copay then plan pays 100%	$20 copay then plan pays 100%
Non-preferred Brand	Not covered	Not covered	Not covered
Supply Limit	100 days	100 days	100 days

HEALTH NET MEDICAL PLAN – HMO

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

	Health Net Medical HMO
	In-Network
Annual Deductible	$0 per individual
Annual Out-of-Pocket Max	$3,400 per individual
Lifetime Max	Unlimited
Office Visit	
Primary Provider	$10 copay
Specialist	$10 copay
Preventive Services	Plan pays 100%
Chiropractic Care	$5 copay (up to 20 visits per year)
Lab and X-ray	Plan pays 100%
Inpatient Hospitalization	Plan pays 100%
Outpatient Surgery	Plan pays 100%
Urgent Care	$20 copay (copay waived if admitted)
Emergency Room	$20 copay (copay waived if admitted)

HEALTH NET PRESCRIPTION DRUG PLAN

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure.

Below is the prescription drug plan offered with our Health Net medical plan.

	Health Net Rx HMO
	In-Network
Annual Out-of-Pocket Limit	$4,130 per individual
Pharmacy	
Generic	$10 copay
Preferred Brand	$20 copay
Non-preferred Brand	$35 copay
Supply Limit	30 days
Mail Order	
Generic	$20 copay
Preferred Brand	$40 copay
Non-preferred Brand	$70 copay
Supply Limit	100 days

HEALTH NET HEALTHY DISCOUNTS

With Healthy Discounts, Health Net members get value-added discounts that help them save on lifestyle improvement services, products and more! Log in as a member at www.healthnet.com , click on Wellness Center, scroll down to Healthy Discounts, and select View All Discounts to learn more about these discounts and how to access them.

Please note that the items outlined below will be included only as they relate to your plan choice. Not all services are available in all plan areas, and hours of operation are subject to change.

Weight Watchers – Offering two weight-loss solutions at a Health Net member exclusive discount – WW Digital and WW Digital and Workshops.

Jenny Craig – Jenny Craig provides you with everything you need, so it's easier to reach your goals! Ready to go meals.

ChooseHealthy Program – Acupuncture, Chiropractic, and Therapeutic Massage service discounts.

EyeMed Vision Care – Receive discounts on eye exams, frames and lenses at more than 20,000 locations, including JCPenney Optical, Target Optical, Pearle Vision, and LensCrafters.

Hearing Care Solutions – Health Net members and their families receive free hearing exams and discounts on hearing aids. All hearing aids include a 3-year comprehensive warranty (including loss and damage), 2-year supply of batteries (up to 128 cells), unlimited follow-up visits for one year, and a 60-day evaluation period.

NationsHearing – Free hearing screenings and hearing aids discount program

KAISER MEDICAL PLAN – HMO

Here is an overview of our medical plan offered through Kaiser Permanente.

	Kaiser HMO - KPSA
	In-Network
Annual Deductible	$0 per individual $0 family limit
Annual Out-of-Pocket Max	$1,500 per individual / $3,000 family limit
Lifetime Max	Unlimited
Office Visit	
Primary Provider	$15 copay
Specialist	$15 copay
Preventive Services	Plan pays 100%
Chiropractic Care	$15 copay (combined acupuncture limit: up to 20 visits per year)
Lab and X-ray	Plan pays 100%
Inpatient Hospitalization	Plan pays 100%
Outpatient Surgery	$15 copay
Urgent Care	$15 copay
Emergency Room	Plan pays 100%

KAISER PRESCRIPTION DRUG PLANS – HMO

Below is the prescription drug plan offered with our Kaiser Permanente medical plan.

	Kaiser Rx HMO
	In-Network
Pharmacy	
Generic	$10 copay then plan pays 100%
Preferred Brand	$20 copay then plan pays 100%
Supply Limit	100 days
Mail Order	
Generic	$10 copay then plan pays 100%
Preferred Brand	$20 copay then plan pays 100%
Supply Limit	100 days

UNITED HEALTHCARE MEDICAL PLAN – HMO

Here is an overview of our medical plan offered through United Healthcare.

	UHC Medical HMO
	In-Network
Annual Deductible	$0 per individual
Annual Out-of-Pocket Max	$6,700 per individual
Lifetime Max	Unlimited
Office Visit	
Primary Provider	$15 copay
Specialist	$15 copay
Preventive Services	Plan pays 100%
Chiropractic Care	$15 copay (up to 12 visits per year)
Lab and X-ray	Plan pays 100%
Inpatient Hospitalization	$250 copay
Outpatient Surgery	$125 copay
Urgent Care	$15 copay (copay waived if admitted)
Emergency Room	$50 copay (copay waived if admitted)

UNITED HEALTHCARE PRESCRIPTION DRUG PLAN

Below is the prescription drug plan offered with our United Healthcare medical plan.

	UHC Rx HMO
	In-Network
Annual Out-of-Pocket Limit	$4,130 per individual
Pharmacy	
Generic	$10 copay
Preferred Brand	$20 copay
Non-preferred Brand	$20 copay
Supply Limit	30 days
Mail Order	
Generic	$20 copay
Preferred Brand	$40 copay
Non-preferred Brand	$40 copay
Supply Limit	90 days

TURNING 65? UNDERSTAND YOUR MEDICARE OPTIONS

Alliant Medicare Solutions is a no cost service available to you, your family members, and friends nearing age 65.

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

Whether you retire or continue to work, choosing the right healthcare option is an important decision when you reach age 65

Most people become eligible for Medicare at age 65. When that happens, you'll probably have some time-sensitive decisions to make, based on your individual situation.

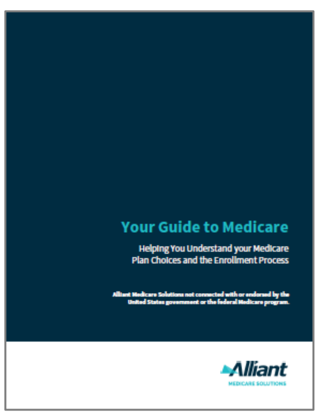
Introducing Alliant Medicare Solutions

Medicare can be complicated. Figuring out the rules—not to mention how Medicare works with or compares to your employer-provided medical coverage—can be a headache. That's why we are offering Alliant Medicare Solutions. The licensed insurance agents at AMS can help you understand Medicare, what is and isn't covered, and how to choose the best coverage for your situation.

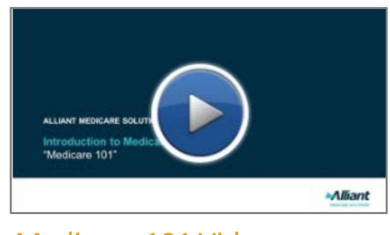
How does it work?

1. Call Alliant Medicare Solutions at **(877) 888-0165** to speak to a licensed insurance agent. Have your current medical coverage information available when you call.
2. Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work the best for you.
3. If Medicare is the best option, Alliant Medicare Solutions helps you enroll immediately or emails policy materials for you to review and enroll at a later date.

Find Out More



Your Guide to Medicare



Medicare 101 Video

Social Security Planning Video

EVERY LIFE INCLUDES TRANSITIONS

GET THE ANSWERS YOU NEED

Transitions offers individualized education and advice about your options related to:

- Medicare coordination
- Social Security planning
- Retirement readiness
- COBRA alternatives
- Caregiving

A benefit for all ages and stages of life

It's said that the only constant in life is change. Whether that means getting ready for retirement, becoming one of the 31.8 million American workers who's also a caregiver for a loved one, or trying to figure out how to continue your benefits coverage through COBRA after a job transition, you'll probably have questions when you face life's many changes. That's where Transitions comes in.

No-cost resources and advice for your situation

If you or your family members need to know more about Medicare, Social Security, retirement, or COBRA, Transitions can provide resources such as videos, webinars, and interactive how-tos. You can even get individualized support for your specific scenario. Some examples:

- Your relative is ill and needs help finding a long-term care facility immediately.
- You're retiring in the next few years and you're not sure what to do about Medicare and Social Security.
- You're prescribed a medication that isn't covered under your insurance and is too expensive to pay for on your own.
- Your spouse—whose insurance covered the whole family—has been laid off, and COBRA is so expensive.

Transitions is available to you, your spouse, and your family members. There are no age requirements to use this benefit.

Getting started is easy

To access your Transitions benefits, sign up at transitionsrbg.com or download the Transitions RBG app. Once you've provided some information, Transitions will verify your benefit and you'll have access to all Transitions benefits. And just so you know, Transitions doesn't store any of your personally identifiable information.

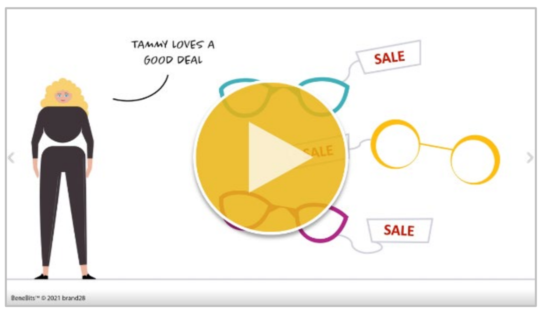
You can also email info@transitionsrbg.com or call (800) 936-1405 if you have questions.

VISION

OUR PLANS

VSP VISION

Click to play video



We offer one vision plan through VSP.

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

Routine vision exams can not only correct vision, but also detect more serious health conditions. When you enroll in the Vision Service Plan Vision plan, you are also provided with coverage through Vision Service Plan.

	Vision Service Plan Vision	
	In-Network	**Out-Of-Network**
Examination		
Benefit	Plan pays 100%	Reimbursed up to $50
Frequency	1x every 12 months from last date of service	In-network limitations apply
Materials	Plan pays 100%	Plan pays 100% (see schedule below)
Eyeglass Lenses		
Single Vision Lens	plan pays 100% of basic lens	Reimbursed up to $50
Bifocal Lens	plan pays 100% of basic lens	Reimbursed up to $75
Trifocal Lens	plan pays 100% of basic lens	Reimbursed up to $100
Frequency	1x every 12 months from last date of service	In-network limitations apply
Frames		
Benefit	Reimbursed up to $150, plus 20% discount from the remaining	Reimbursed up to $70
Frequency	1 x every 24 months from last date of service	In-network limitations apply
Contacts (Elective)		
Benefit	Fitting & evaluation exam: Reimbursed up to $130	Reimbursed up to $105 (in-network limitations apply)
Frequency	1 x every 12 months from last date of service	In-network limitations apply

VSP RESOURCES

VSP Vision Riders and Discounts

- A vision exam helps detect the signs of health conditions like high blood pressure, diabetes, and high cholesterol—along with other eye and health issues.

Better provider choice with VSP

- You can choose your provider from 71,000 access points, including the largest national network of independent doctors and nearly 4,500 participating retail chain locations. For convenience, most VSP participating doctors also offer early morning, evening and weekend appointments, and 24-hour access to emergency care.
- If you prefer to use a non-network provider, this option is also available under our plan however, the benefit allowances are lower.

Exclusive member discounts & Extra savings on glasses & sunglasses

- Extra $20 to spend on featured frame brands. Go to www.vsp.com/specialoffers for details.
- 30% savings 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.
- Eyeconic®, an easy-to-use, in-network, online eyewear platform is also available to all members. Eyeconic® offers free shipping and returns, virtual try-on tool, free frame adjustment or contact lens consultation and all-inclusive pricing on glasses and lenses. For more information on Eyeconic®, visit eyeconic.com

Laser vision correction

- Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor

Hearing aid discount

VSP® Vision Care members can save up to $2,400 on a pair of digital hearing aids. Dependents and even extended family members are eligible for exclusive savings, too.

TruHearing also provides members with:

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

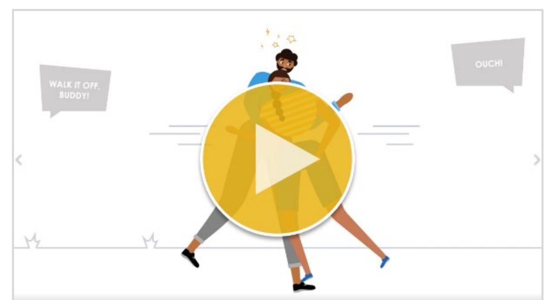
ENGAGE

Maximize Your Healthcare

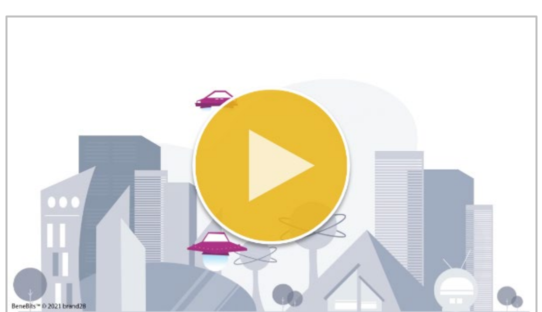
Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs

Click to play video



Urgent Care vs ER



Virtual Healthcare

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline	Quick answers from a trained nurse	▪ Identifying symptoms ▪ Decide if immediate care is needed ▪ Home treatment options and advice	24/7	$0
Online visit	Many non-emergency health conditions	▪ Cold, flu, allergies ▪ Headache, migraine ▪ Skin conditions, rashes ▪ Minor injuries ▪ Mental health concerns	24/7	$
Office visit	Routine medical care and overall health management	▪ Preventive care ▪ Illnesses, injuries ▪ Managing existing conditions	Office Hours	$$
Urgent care, walk-in clinic	Non-life-threatening conditions requiring prompt attention	▪ Stitches ▪ Sprains ▪ Animal bites ▪ Ear-nose-throat infections	Office Hours, or up to 24/7	$$$
Emergency room	Life-threatening conditions requiring immediate medical expertise	▪ Suspected heart attack or ▪ stroke ▪ Major bone breaks ▪ Excessive bleeding ▪ Severe pain ▪ Difficulty breathing	24/7	$$$$$

ALTERNATIVE FACILITIES

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Need	Alternative	Features	Savings
Surgery	Ambulatory Surgery Center (ASC)	▪ Specializes in same-day surgeries ▪ Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more ▪ Held to same safety standards as hospitals	Up to 50% over hospital stay*
Physical therapy	Free-standing physical therapy center	▪ Important part of the recovery process after an injury or surgery	40 to 60% over a hospital setting*
Sleep study	Home testing	▪ Diagnoses sleep apnea and other conditions ▪ Cost is often covered by insurance if considered medically necessary	Approx. $4,500*
Infusion therapy	Home or outpatient infusion therapy	▪ For drugs that must be delivered by intravenous injections, or epidurals ▪ Delivered by licensed infusion therapy provider ▪ Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% over hospital stay*

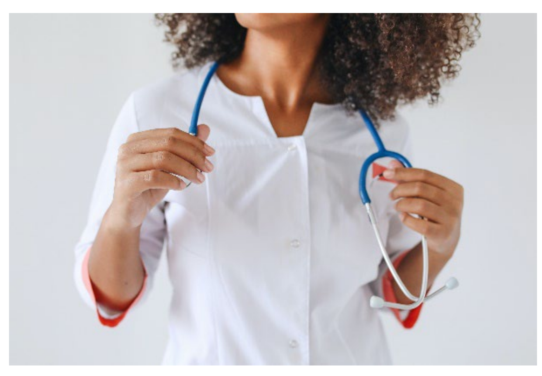
**in-network*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital. You can also search for surgical centers, physical therapy, etc. on your plan's website; or call member services for assistance.

Online tools such as healthcarebluebook.com and healthgrades.com help you compare costs and doctor ratings. Some alternative services include a facility fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

PREVENTIVE CARE SCREENING BENEFITS



TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit cdc.gov/prevention for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name drug equivalents.

To find out if a drug is on your plan's formulary, visit the plan's website or call the customer service number on your ID card.

IMPORTANT PLAN INFORMATION

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

- A Benefits Glossary to help you understand important insurance terms.
- 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

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 CLIENT NAME if your domestic partner is your tax dependent.

PLAN CONTACTS

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

Plan Type	Provider	Phone Number	Website	Policy No.
Medical	Anthem (Teamsters)	(800) 888-8288	teamsters.org	EPO – 280436 PPO - 280558
	Kaiser (Teamsters)	(800) 464-4000	teamsters.org	HMO/KPSA - 7038
	Health Net (Direct)	(800) 447-8812	healthnet.com	90303
	United HealthCare (Teamsters)	(800) 624-8822	teamsters.org	141320
Vision	VSP (PRISM)	(800) 877-7195	vsp.com	12137687
Teamsters	Teamsters Assistance Program	(510) 562-3600	tap-program.org/	N/A
Human Resources	City of Pittsburg	(925) 252-4878	ci.pittsburg.ca.us/	N/A

GLOSSARY

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.

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.

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 underage 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

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

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 here.

- **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
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.
- **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

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 Pittsburg 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 Pittsburg 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 Pittsburg 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.

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 The City of Pittsburg coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan. **Important Note for Retiree Plans:** Certain retiree plans will terminate RX coverage when an individual enrolls in Medicare Part D and individuals might not be able to re-enroll in that coverage. If completing this Notice for a retiree plan, review the plan provisions before completing this form and modify this section as needed.

Since the existing prescription drug coverage under The City of Pittsburg is 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 The City of Pittsburg 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 The City of Pittsburg 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 [or call The City of Pittsburg at 925-252-4878 .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 The City of Pittsburg 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
- 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, 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: 01/01/2023
Name of Entity/Sender: The City of Pittsburg
Contact-Position/Office: Human Resources
Address: 65 Civic Avenue, Pittsburg, CA 94565
Phone Number: 925-252-4878

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. Therefore, the following deductibles and coinsurance apply. 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 at 925-252-4878 .

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in The City of Pittsburg 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 The City of Pittsburg 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 The City of Pittsburg 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 Pittsburg describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting your health plan.

Notice of Choice of Providers

Kaiser Permanente generally allows 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 the health plan.

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

You do not need prior authorization from Kaiser Permenente 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.

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 January 31, 2023. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 | Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
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://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov | KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 | Kentucky Medicaid Website: https://chfs.ky.gov
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.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 | TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 617-886-8102
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp | Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP

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

SOUTH CAROLINA – Medicaid

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

SOUTH DAKOTA – Medicaid

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

TEXAS – Medicaid

Website: http://gethipptexas.com/ | Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

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

VERMONT – Medicaid

Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924 | 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