Employee

BENEFITS Guide

2022

Employee Benefits Guide 2022

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

Please see page 30 for more details.

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

Introduction

The Superior Court of Fresno County understands the importance of offering a comprehensive benefit program that meets the needs of our workforce. We are pleased to provide a suite of quality benefit plans to all benefit eligible employees for the January 1, 2022 plan year.

2022 Core Plan Offerings

- Blue Shield HMO
- Blue Shield PPO
- Blue Shield HDHP
- Kaiser Permanente HMO
- Kaiser Permanente HDHP
- Optum HSA
- Superior Vision
- Delta Dental PPO
- MetLife DHMO
- Magellan EAP
- Cigna Life & AD&D

Voluntary Benefits

- Flexible Spending Accounts
- Long Term Disability
- Cancer Insurance
- Accident Insurance
- Home and Auto Insurance

Or Enroll or Join

- The Deferred Compensation program
- Noble Credit Union

Benefit Choices

The Court recognizes that your benefits are an important part of the reason you choose to work here. The Court provides a variety of high quality benefits at a reasonable cost to you. Since you have some choices to make, it is important to understand the various programs, which is why this Handbook is being provided for you. There are also individual brochures for each of the benefit plans available in HR or on the ADP web portal.

Eligibility

Employees

Employees filling regular, full-time positions are eligible for coverage under the plan. Employees filling regular, part-time positions are eligible for coverage under the plan if they are working at least 50% of the normal bi-weekly pay period; however, part-time employees' costs shall be pro-rated. Employees filling Extra Help positions are eligible for medical, dental, and vision coverage after 90 days of employment.

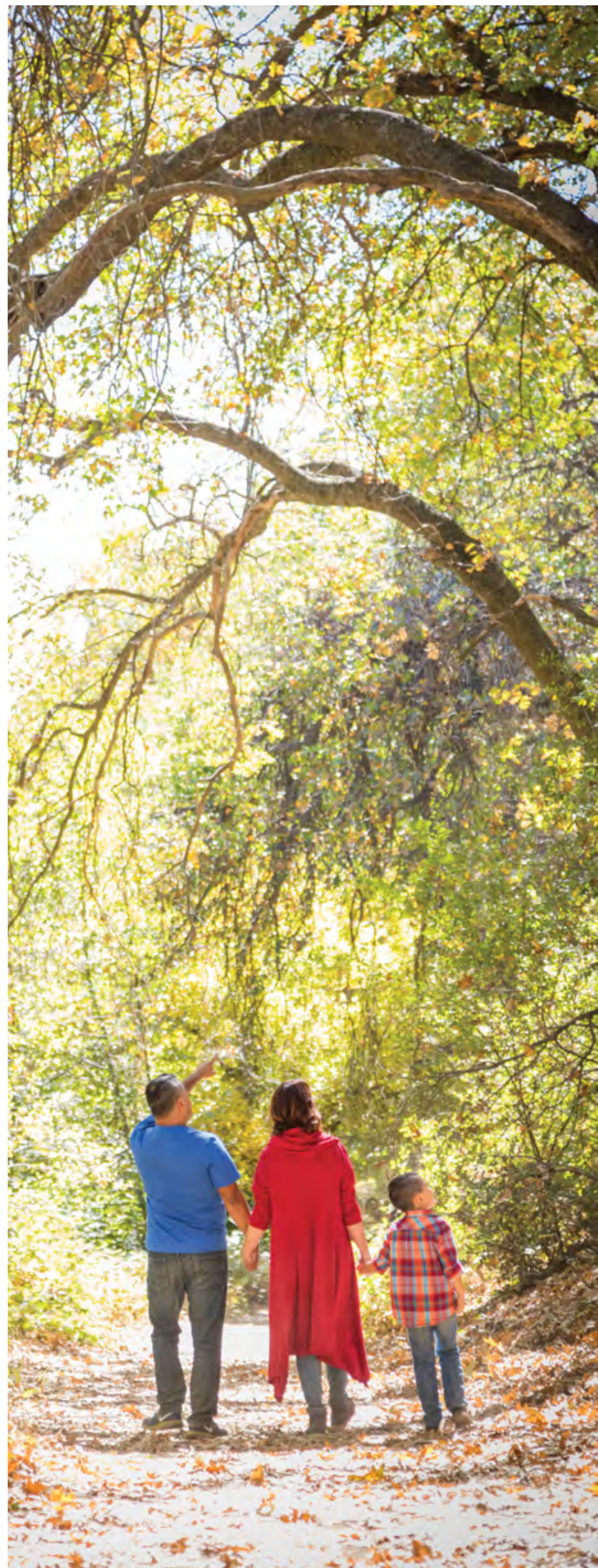
Eligible employees are required to maintain medical, dental, and vision coverage at all times. The choice for employee and dependent health insurance coverage must be made within the first thirty (30) days of employment or eligibility, or during the annual open enrollment period. If no selection is made within the allotted time limit, the Court will automatically enroll the employee (excluding dependents) into the plan with the least out-of-pocket cost to the Court.

Employees may opt out of the Court's health insurance plan by providing the HR department with written proof of other employer sponsored group coverage and submitting a completed opt out form.

Active Employment

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

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



Eligibility (continued)

Dependents

When enrolling dependents, appropriate documentation and/or proof of dependent status is required by the Court and will be requested by Human Resources.

Accepted forms of proof include: Marriage and Birth Certificates, Tax Returns, State Issued Declaration of Domestic Partnership, Adoption Certificate or Proof of Legal Guardianship.

An eligible dependent of an employee is:

- A legally married spouse
- A registered domestic partner
- A Child, up to age 26.
  For these purposes a "child" will include:
  - Biological Child
  - Stepchildren
  - Children of a registered domestic partner
  - Legally adopted children (including a child for whom legal adoption proceedings have been started)
  - Any other child for whom you are required to provide health plan coverage under a Qualified Medical Child Support Order
  - A disabled child at any age, as long as he/she continues to meet the conditions as defined by Section 12102 of the Americans with Disabilities Act (ADA)

Non-Eligible Dependents

An eligible dependent does not include:

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

Dual Coverage

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

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

Change in Dependent Eligibility

It is the employee's responsibility to notify the Court's HR Office within 30 days or sooner of a dependent's change in status that would make the dependent eligible or ineligible for benefit coverage. Some examples of a change in dependent status are birth, death, adoption or divorce.

Continuation of Coverage (COBRA)

While you must delete your ineligible dependent within 30 days of the loss of eligibility, failure to delete your ineligible dependent within 60 days of loss of eligibility will result in a loss of continuation of coverage rights (COBRA) for your dependents.

Change in Beneficiaries

Certain events in your life such as marriage, divorce, or a death in the family can affect who you name as your designated beneficiary for certain benefits. You may change your beneficiary(ies) at any time. If you wish to do so, you can obtain most beneficiary forms from HR or change them through the ADP portal. You must designate a beneficiary for Basic Life Insurance.

Coverage Effective Dates

Regular Employees

Medical, Dental and Vision coverage are effective on the date of hire when you complete and return the enrollment form within 30 days of your hire date. Life insurance is effective on the first of the month following the date of hire.

As a new hire, to receive the coverage you want, you must enroll yourself and your eligible dependents within the 30 day eligibility period. If you do not enroll, you will automatically be enrolled in the lowest cost plans, without your dependents. Your next opportunity to change coverage or add dependents will be during the next annual enrollment period, unless your dependents experience a qualifying event.

Extra Help Employees

Employees classified as Extra Help are eligible for benefits at the start of the pay period which includes the 90th day of employment. Employees are able to enroll in medical, dental and vision plans and add any eligible dependents.

Open Enrollment

During the scheduled open enrollment period, you can select a new medical plan, add or delete dependents without a qualifying event, or enroll in one of the many voluntary plans including life insurance. This is also the time of year to enroll in a medical and/or dependent care flexible spending account. Anyone currently participating in the flexible spending account programs must re-enroll in order to continue coverage in the 2022 plan year.

Supporting documentation will be required by Human Resources to add new dependents.

Changing plans and adding or deleting qualified dependents may affect the premium you pay through payroll deductions. The changes requested will take place effective January 1, 2022 and will be reflected on the paycheck you receive on January 15, 2022.

ADP Information

All employees are required to enroll in the health plans through the ADP portal at workforcenow.adp.com or by calling ADP Customer Service at 855.547.8508.

Medicare While Working

If you are eligible to participate in the Court's medical plans as an active employee and wish to continue working after reaching age 65, you have important options to consider when approaching Medicare eligibility. While you are still an active benefited employee under a Court medical plan, you may be able to delay enrollment in some parts of Medicare without incurring a late enrollment penalty at a later date. Your Court medical plan remains primary to Medicare while you are working.

For details of what's covered under Medicare, how to enroll, and your option regarding Medicare coverage, contact your local Social Security office or visit medicare.gov on the web.

Changes in Coverage

Qualifying Events

You may experience certain events during the plan year that would allow you to change yours or your dependent's medical coverage. If any of the following events occur, you must change your benefit coverage within 30 days of the event:

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

Special Enrollment Rights as Provided by HIPAA

- You initially declined coverage under the plan because you had coverage under another plan, and subsequently incurred a loss of coverage under the other plan.
- Occurrence of certain events such as birth, adoption, placement for adoption or marriage.
- Eligibility for state premium subsidies under the Children's Health Insurance Program or State Children's Health Insurance Program.
- Loss of coverage under Medicaid, The Children's Health Insurance Program or State Children's Health Insurance Program.

Health Savings Account

If you enroll in a High Deductible Health Plan (HDHP) you have the option of opening a Health Savings Account (HSA) with Optum, as long as you meet the eligibility guidelines.

An HSA is a voluntary savings account established for reimbursement of qualified medical expenses. HSAs were created to provide individuals with a tax saving benefit for certain medical expenses when covered under a HDHP.

An HSA in not a medical plan with a carrier. It is an individual account established for your contributions and expenses. It is able to reimburse the same category of eligible expenses as a Medical Flexible Spending Account, however your maximum available reimbursement is limited to your account balance.

Among the benefits of an HSA are:

- Contributions are exempt from Federal (not State) taxes;
- Interest and earnings are exempt from Federal taxes;
- Distributions are tax free when used for qualified medical expenses as listed under IRS Code 213 (d) such as copays, deductibles, dental vision expenses and more;
- Assets roll over from year to year - no "use it or lose it";
- You can change the contribution at any time;
- The HSA is portable, so you can use the assets even if you leave the Court's employment.

In order to be eligible to contribute to an HSA, you must:

- Be enrolled in an HDHP;
- Have no other non-HDHP health coverage;
- Not be enrolled in Medicare
- Have not received VA medical benefits at any time over the past three months;
- Not be able to be claimed as a dependent on someone else's tax return;
- Not be contributing to a general purpose medical Flexible Spending Account (FSA). However, you may contribute to a limited purpose medical FSA for qualifying dental and vision expenses only, and also contribute to an HSA.

Even if you are no longer eligible to contribute to an HSA, whether you switch from a HDHP or leave the Court employment, your HSA account remains active for the reimbursement of qualified medical expenses until it is depleted. Non medical withdrawals are considered taxable income and will have a 20% penalty if you are under 65.

Deductible minimums and contribution maximums are set by the IRS each year. For the 2022 plan year:

Minimum Deductibles

- **Individual:** $1,400
- **Family:** $2,800

Contribution Maximums

- **Individual:** $3,600
- **Family:** $7,200

An additional $1,000 can be contributed over the age of 55.

Medical – Kaiser Permanente

Care of Services	Kaiser Permanente HMO	Kaiser Permanente HDHP $1,400
General Plan Information		
• Annual Deductible		Everything is subject to deductible unless otherwise stated
– Individual/Family	$0/$0	$1,400/$2,800
• Coinsurance	100%	100%
• Office Visit/Exam	$15 copay	$20 copay
• Outpatient Specialist Visit	$15 copay	$20 copay
• Annual Out-of-Pocket Limit *(Individual/Family)*	$1,500/$3,000	$3,000/$6,000
• Deductible Included in Out-of-Pocket Limits	N/A	Yes
• Lifetime Plan Maximum	Unlimited	Unlimited
• Primary Care Physician Election Required	Yes	Yes
Outpatient Services		
• Well-Child Care	100%	100% (deductible waived)
• Immunizations	100%	100% (deductible waived)
• Well-Woman Exams	100%	100% (deductible waived)
• Mammograms	100%	100% (deductible waived)
• Adult Periodic Exams with Preventive Tests	100%	100% (deductible waived)
• Diagnostic X-Ray and Lab Tests	100%	$10 copay; 100% for Preventive (deductible waived)
Maternity Care		
• Pregnancy and Maternity Care *(Pre-Natal Care)*	100%	100% (deductible waived)
Inpatient Hospital Services		
• Inpatient Hospitalization	100%	$250 copay/admit
• Pre-Authorization of Services Required	Yes	Yes
• Semi-Private Room & Board; including Services and Supplies	100%	$250 copay/admit
Surgical Services		
• Outpatient Facility Charge	$15 copay/procedure	$150 copay/procedure
Emergency Services		
• Emergency Room	$100 copay (waived if admitted)	100% + $100 copay (copay waived if admitted)
• Ambulance *(air or ground)*	$50 copay/trip	$100 copay/trip
Urgent Care		
• Urgent Care Facility	$15 copay	$20 copay
Mental Health Benefits		
• Inpatient Care	100%	$250 copay/admit
• Outpatient Care	$15 copay for individual visits; $7 copay for group visits	$20 copay for individual visits; $10 copay for group visits

The information on this page is intended to be a summary of your benefit provisions, limitations and exclusions. Please review your Summary Plan Description (SPD) for a complete summary of benefits.

Medical – Kaiser Permanente (continued)

Care of Services	Kaiser Permanente HMO	Kaiser Permanente HDHP $1,400
Substance Abuse		
• Inpatient Care		
– Inpatient Hospitalization	100%	$250 copay/admit
– Inpatient Detoxification Services	100%	$250 copay/admit
• Outpatient Care		
– Outpatient Services	$15 copay for individual visits; $5 copay for group visits	$20 copay for individual visits; $5 copay for group visits
Prescription Drugs		
• Retail		
– Generic	$10 copay	$10 copay
– Brand *(Formulary/Preferred)*	$20 copay	$30 copay
– Specialty Rx	20% up to $200	20% up to $150
– Number of Days Supply	30 days	30 days
Mail Order		
– Generic	$20 copay	$20 copay
– Brand *(Formulary/Preferred)*	$40 copay	$60 copay
– Number of Days Supply	100 days	100 days
Other Services and Supplies		
• Durable Medical Equipment and Prosthetic Devices	80% for DME; 100% for Prosthetic Devices	80% for DME; 100% for Prosthetic Devices
• Home Health Care	100%; limited to 100 visits/calendar year	100%; limited to 100 visits/calendar year
• Skilled Nursing or Extended Care Facility	100%; limited to 100 days/benefit period	$250 copay/admit; limited to 100 days/benefit period
• Hospice Care	100%	100% covered
• Chiropractic Services	$10 copay; limited to 30 visits/calendar year; services provided by American Specialty Health	Not covered
• Acupuncture	$15 copay	$20 copay
Vision		
• Copay		
– Allowance Amount	$175	N/A
– Exam	$0 copay	$20 copay
– Materials	See Allowance Amount	Not covered
• Benefit Frequency		
– Exam	12 months	N/A
– Lenses	24 months	N/A
– Frames	24 months	N/A
– Contacts	24 months; in lieu of lenses and frames	N/A

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Medical – Kaiser Permanente (continued)

Care of Services	Kaiser Permanente HMO	Kaiser Permanente HDHP $1,400
Hearing		
• Screening	$15 copay	$20 copay
• Aid(s)	$1,000 allowance/device; one device/ear; two devices/36 months	Not covered
Infertility		
• Diagnosis	See Plan Certificate	Not covered
• Treatment	See Plan Certificate	Not covered
Outpatient Rehabilitative Therapy Services		
• Physical	$15 copay	$20 copay
• Occupational	$15 copay	$20 copay
• Speech	$15 copay	$20 copay

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Medical – Blue Shield

Benefits at a Glance	Blue Shield HMO	Blue Shield PPO		Blue Shield HDHP	
		In-Network	Out-of-Network	In-Network	Out-of-Network
General Plan Information					
• Annual Deductible		Everything is subject to deductible unless otherwise stated		Everything is subject to deductible unless otherwise stated	
– Individual/Family	$0/$0	$250/$500	$250/$500	$1,400/$2,800	$1,400/$2,800
• Coinsurance	100%	100%	50%	100%	50%
• Office Visit/Exam	$15 copay	$20 copay (deductible waived)	50%	100%	50%
• Outpatient Specialist Visit	$30 copay	$20 copay (deductible waived)	50%	100%	50%
• Annual Out-of-Pocket Limit					
– Individual/Family	$1,500/$3,000	$3,250/$6,500	$6,250/$12,500	$2,800/$5,400	$5,000/$10,000
• Deductible included in Out-of-Pocket Limits	N/A	Yes	Yes	Yes	Yes
• Lifetime Plan Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
• Primary Care Physician Election Required	Yes	N/A	N/A	N/A	N/A
Outpatient Services					
• Well-Child Care	100%	100% (deductible waived)	Not covered	100% (deductible waived)	Not covered
• Immunizations	100%	100% (deductible waived)	Not covered	100% (deductible waived)	Not covered
• Well-Woman Exams	100%	100% (deductible waived)	Not covered	100% (deductible waived)	Not covered
• Mammograms	100%	$20 copay (deductible waived for preventive)	50%	100% (deductible waived if preventive)	50%
• Adult Periodic Exams with Preventive Tests	100%	100% (deductible waived)	Not covered	100% (deductible waived)	Not covered
• Diagnostic X-Ray and Lab Tests	100%	$20 copay (deductible waived for preventive)	50%	100% (deductible waived if preventive)	50%
Maternity Care					
• Pregnancy and Maternity Care *(Pre-Natal Care)*	100%	100%	50%	100%	50%
Inpatient Hospital Services					
• Inpatient Hospitalization	100%	$100 copay/admit	50%; $600 max allowed charge per day	100%	50%; $600 max allowed charge per day
• Pre-Authorization of Services Required	Yes	Yes	Yes	Yes	Yes
• Semi-Private Room & Board; including Services and Supplies	100%	$100 copay/admit	50%; $600 max allowed charge per day	100%	50%; $600 max allowed charge per day
Surgical Services					
• Outpatient Facility Charge	100%	100%	50%; $350 max allowed charge per day	100%	50%; $350 max allowed charge per day

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Medical – Blue Shield (continued)

Benefits at a Glance	Blue Shield HMO	Blue Shield PPO		Blue Shield HDHP	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Services					
• Emergency Room	$100 copay (waived if admitted)	$100 copay (deductible waived if admitted)	$100 copay (deductible waived if admitted)	100%	100%
• Ambulance *(air or ground)*	$100 copay	100%	100%	100%	100%
Urgent Care					
• Urgent Care Facility	$15 copay	$20 copay	50%	100%	50%
Mental Health Benefits					
• Inpatient Care	100%	$100 copay/admit	50%; $600 max allowed charge per day	100%	50%; $600 max allowed charge per day
• Outpatient Care	$15 copay	$20 copay (deductible waived)	50%	100%	50%
Substance Use Disorder					
• Inpatient Care					
– Inpatient Detoxification Services	100%	$100 copay/admit	50%; $600 max allowed charge per day	100%	50%; $600 max allowed charge per day
• Outpatient Care					
– Outpatient Services	$15 copay	$20 copay (deductible waived)	50%	100%	50%
Prescription Drugs					
• Deductible	N/A	N/A	N/A	Subject to annual deductible	Subject to annual deductible
• Retail					
– Generic	$10 copay	$10 copay	$10 copay + 25%	$10 copay	$10 copay + 25%
– Brand *(Formulary/Preferred)*	$25 copay	$20 copay	$20 copay + 25%	$25 copay	$25 copay + 25%
– Brand *(Non-Formulary/ Non-Preferred)*	$40 copay	$35 copay	$35 copay + 25%	$40 copay	$40 copay + 25%
– Specialty Rx	20% up to $200	30% up to $250	30% up to $250 + 25%	30% up to $200	30% up to $200 + 25%
– Number of Days Supply	30 days	30 days	30 days	30 days	30 days
• Mail Order					
– Generic	$20 copay	$20 copay	Not covered	$20 copay	Not covered
– Brand *(Formulary/Preferred)*	$50 copay	$40 copay	Not covered	$50 copay	Not covered
– Brand *(Non-Formulary/ Non-Preferred)*	$80 copay	$70 copay	Not covered	$80 copay	Not covered
– Number of Days Supply	90 days	90 days	N/A	90 days	N/A

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Medical – Blue Shield (continued)

Benefits at a Glance	Blue Shield HMO	Blue Shield PPO		Blue Shield HDHP	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Other Services and Supplies					
• Durable Medical Equipment and Prosthetic Devices	50% for DME; 100% for Prosthetic Devices including Orthotics	100%	50%	100%	50%
• Home Health Care	$15 copay; limited to 100 visits/calendar year	100%; limited to 100 visits/calendar year	Not covered unless authorized	100%; limited to 100 visits/calendar year	Not covered unless authorized
• Skilled Nursing or Extended Care Facility	100%; limited to 100 days/calendar year	100%; limited to 100 days/calendar year	100% in a free standing facility; limited to 100 days/calendar year	100%; limited to 100 days/calendar year	100% in a free standing facility; 50% in a hospital unit
• Hospice Care	100%	100%	Not covered	100%	Not covered
• Chiropractic Services	$10 copay; limited to 30 visits/calendar year	$25 copay; limited to 12 visits/calendar year	50%; limited to 12 visits/calendar year	100%; limited to 20 visits/calendar year	50%; limited to 20 visits/calendar year
• Acupuncture	Not covered	$25 copay; limited to 20 visits/calendar year	50%; limited to 20 visits/calendar year	Not covered	Not covered
Hearing					
• Screening	100%; up to age 18	Not covered	Not covered	Not covered	Not covered
• Aid(s)	Not covered	Not covered	Not covered	Not covered	Not covered
Infertility					
• Diagnosis	See Plan Certificate	Not covered	Not covered	Not covered	Not covered
• Treatment	See Plan Certificate	Not covered	Not covered	Not covered	Not covered
Outpatient Rehabilitative Therapy Services					
• Physical	$15 copay	$20 copay	50%	100%	50%
• Occupational	$15 copay	$20 copay	50%	100%	50%
• Speech	$15 copay	$20 copay	50%	100%	50%

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Dental

The Court offers two comprehensive dental plans to choose from.

Delta Dental

Delta Dental is a PPO plan that pays for a portion of the bill once a deductible is met. You have the option to use any dentist of your choosing. If a participating dentist is selected, you will have lower out-of-pocket costs for services. Out-of-network dentists are paid based on the PPO fee schedule. You will be responsible for any amount not covered by Delta Dental.

MetLife

MetLife is a DHMO plan that has no deductible or annual maximum. You will pay copays for services from your participating dentist. You will pick one participating dentist to receive care from.

Type of Benefit	Delta Dental		MetLife
	In-Network	Out-of-Network *	
Deductible	$50 per person/$150 per family each calendar year		$0
Calendar Year Max	$2,500; Diagnostic and Preventive not subject to calendar year max		Unlimited
Preventive			
• Exams and Cleanings	100%	90%	$0 copay
• Full Mouth X-Ray Series or Panoramic X-Ray	100%	90%	$0 copay
• Bitewing X-Rays	100%	90%	$0 copay
• Sealants	90%	90%	$0 copay
Basic Restorative			
• Anterior Composite *(ADA 2330)*	90%	90%	$0 copay
• Molar Root Canal *(ADA 3330)*	50%	50%	$95 copay
• Periodontic Treatment *(ADA 4210)*	50%	50%	$50 copay
• Surgical Extraction *(ADA 7210)*	50%	50%	$15 copay
Major Restorative			
• Crown *(ADA 2750)*	50%	50%	$100 copay (additional metal or porcelain fee may apply)
• Denture *(ADA 5110/5120)*	50%	50%	$125 copay
• Fixed Bridge Crown *(ADA 6750)*	50%	50%	$225 copay (additional metal or porcelain fee may apply)
Orthodontics			
• Comprehensive Treatment *(ADA 8070, 8080, 8090)*	**Children:** $1,660 copay **Adults:** $1,880 copay		$1,450 copay

* Out-of-Network Dentists are covered at the applicable coinsurance level of the PPO fee schedule.

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Vision

The Court offers a vision plan with Superior Vision, which allows you to see any provider. With a contracted provider, you will have less out-of-pocket costs than with one outside of the network.

Plan Benefits	Superior Vision	
	In-Network	Out-of-Network
Frequency of Services		
• Vision Exam	Once every 12 months	
• Eyeglass Lenses	Once every 12 months	
• Frames	Once every 24 months	
• Contact Lenses	Once every 12 months	
• Contact Lens Fitting	Once every 12 months	
Copay *(per Insured)*		
• Vision Exam	$5	N/A
• Eyeglass Lenses/Frames	$0	N/A
• Contact Lens Fitting	$35	N/A
Benefits and Allowances		
• Vision Exam		
– Ophthalmologist (M.D.)	100%	$40 allowance
– Optometrist (O.D.)	100%	$30 allowance
• Materials – Lenses		
– Single Vision	100%	$35 allowance
– Progressive	Covered at lined trifocal level	$60 allowance
– Bifocals	100%	$50 allowance
– Trifocals	100%	$60 allowance
– Lenticular	100%	$95 allowance
• Materials – Frames *(in lieu of contacts)*	$175 allowance	$88 allowance
• Contacts *(in lieu of frames)*		
– Non-Elective	100%	$210 allowance
– Elective	$130 allowance	$100 allowance
– Standard Fitting	100%	Not covered
– Specialty Fitting	$50 allowance	Not covered

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Employee Assistance Program

The Court provides an Employee Assistance Program (EAP), which is administered by Magellan Health Services. Magellan provides confidential, professional short-term counseling services for you and your eligible family members. They also provide online services for Court employees.

Contacting Magellan

Visit magellanascend.com for Magellan's online services. These services are intended to help you better manage a wide range of emotional health, working, and living challenges.

Or call Magellan directly at 800.424.4039 to make an appointment. This number is available 24 hours a day, seven days a week. All services are confidential and private.

Summary of EAP Plan

The program provides six (6) counseling sessions for each incident/issue per year for you and for each of your eligible dependents, at no cost to you. There are no copay, coinsurance, or deductible payments.

- Face-to-Face Counseling for marital/family concerns, alcohol/drug dependency, relationships, emotional problems, stress, and other issues.
- Telephonic Counseling and/or Web-Video Consultations for a broad range of life management issues including:
  - **Legal Matters:** Advice for family law, consumer issues, landlord/tenant disputes, personal injury, contracts, and criminal matters.
  - **Financial:** Budgeting, credit issues, and financial planning.
  - **Child and Elder Care Assistance:** Assessing needs, choosing resources, and exploring payment options.
  - **Identity Theft Services:** Helps members recover from identity theft and learn how to avoid the problem in the future.

Flexible Spending Accounts

These accounts permit employees to set money aside on a pre-tax basis, via payroll deduction, for eligible medical, dental, vision, or dependent care expenses not covered by insurance or other benefit plans. A new enrollment is required each year, even if you do not plan to change the amount(s) set aside. Except for a change in status event, the only time you can enroll, change, or stop your FSA is during Open Enrollment.

Employees enrolled in a Health Savings Account (HSA) are not eligible to contribute to a general purpose medical reimbursement account. However, they may contribute to a limited purpose medical reimbursement account for qualifying dental and vision expenses only. Please contact HR for more information.

Medical Reimbursement Account (MRA)

The MRA allows you to set aside pre-tax money to pay for out-of-pocket expenses incurred by you for yourself, your spouse or your eligible dependents up to age 26 that are not paid by your insurance or reimbursed by any other benefit plan. Expenses for children that do not qualify as an IRS dependent are generally not allowed, per Federal law. Expenses include, but are not limited to, insurance copays, deductibles, dental or vision expenses, pharmacy bills, and other similar out-of-pocket costs. Up to $550 can be carried over to the 2023 plan year for unused amounts. Any amount exceeding $550 will be forfeited. Effective January 1, 2011 over-the-counter (OTC) medications are no longer reimbursable without a doctor's prescription. An important IRS exclusion is that treatments, services, and surgeries that are performed for cosmetic reasons are not reimbursable from a Flexible Spending Account.

Dependent Care Reimbursement Account (DCRA)

You may set aside pre-tax dollars to pay for qualified childcare or dependent care expenses that are necessary for you and your spouse to continue working or going to school full-time. A new dependent care contract for automatic reimbursement is also required every year.

Amount of Contribution

With the MRA, you may set aside up to $2,750 per calendar year to pay for qualified unreimbursed health expenses. For DCRA, you may defer up to $5,000 ($2,500 if you are married and file separate tax returns) to pay for qualified dependent care expenses.

Claim Reimbursement

You have two options, use the prepaid benefits card or submit claim forms along with all receipts.

Using the prepaid card gives you an easy, automatic way to pay for qualified health care/benefits expenses. The Card lets you electronically access the pre-tax amounts set aside in your Flexible Spending Account. The card works like a MasterCard or Visa. When you have eligible expenses at a place that accepts MasterCard or Visa, simply use your card. The amount of your eligible purchases will be deducted, automatically, from your account.

If you don't use the card, contact your plan administrator at the phone number on the back of your card to obtain a claim form.

Election Changes

The only time you may make any type of change in your deduction elections is during Open Enrollment, or within 30 days of a "change in status" event. Remember: IRS guidelines require that any change you request must be on account of, consistent with, and correspond to your "change in status" event. All changes are on a prospective basis only.

Social Security

Your election may reduce your Social Security contributions. However, the reduction is generally small. You may wish to contact your tax advisor prior to making your election.

Flexible Spending Accounts (continued)

If You Leave Court Employment

Your contributions will cease when your employment ends. The Plan shall reimburse any eligible expenses which were incurred during your coverage in the Plan Year, less benefits already paid during the Plan Year. For Dependent Care expenses, the plan reimburses up to the amount of your contribution for benefits less benefits paid, and for medical expenses incurred prior to your employment termination up to the amount of your annual benefit less benefits paid.

Depending on the timing of the event and your remaining balance available to you, post employment expenses may be eligible for claim reimbursements if you elect to continue contributions on a post tax basis through COBRA, but only for the balance of the plan year. Information regarding COBRA options for the Medical Reimbursement Account, if you qualify, will be sent to your mailing address after your employment ends.

Basic Life and AD&D

Basic Life

The Court provides a Basic Life insurance and Accidental Death & Dismemberment (AD&D) benefit through Cigna, at no cost to the employee. The plan will pay the following amount to your beneficiary at the time of death:

- $15,000 for non-management employees
- $50,000 for management

The AD&D benefit is equal to the amount of the Basic Life coverage.

Don't Forget to Name a Beneficiary

A beneficiary is the person or persons who will be paid if you die while covered by the plan. A person becomes your beneficiary only if you have assigned them through the ADP portal. If you are married and not naming your spouse as the beneficiary, the spouse must sign an acknowledgement.

Group Universal Life

Additional Voluntary Life coverage with a Cash Accumulation Fund Feature

All employees have the opportunity to gain greater financial security for you and your family members by supplementing your Court paid Basic Life coverage.

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

To be eligible for coverage without evidence of insurability (health/or physical exam), up to the lesser of 3x your salary or $150,000, you must enroll yourself and your dependents within 30 days of being eligible for coverage.

- **Spouse:** Coverage for your spouse can be purchased in units of $5,000 up to a maximum of $100,000. Maximum guaranteed issue is $20,000.
- **Children:** Coverage for your child(ren) over 15 days old is available without evidence of insurability up to $10,000.

Voluntary Benefits: American Fidelity

Long Term Disability

How do you pay for your mortgage, bills, food and other monthly expenses? If your paycheck stopped today, could you maintain your current lifestyle?

American Fidelity's Long Term Disability Income Insurance is designed to help protect you if you become disabled and cannot work due to a covered Accidental Injury or Sickness.

Eligibility

Applicant's eligibility for this program may be subject to insurability. It is your responsibility to see the American Fidelity representative once you have satisfied the Court's waiting period.

How the Plan Works

If you become disabled due to a covered accident or sickness, Long Term Disability income insurance will pay up to 60% of your monthly income once you have satisfied the elimination period. Disability benefits will be payable up to the benefit period stated in your policy.

Benefits Begin

Accidental Injury and Sickness benefits will be payable as early as the 8th day of disability and continue up to Social Security Normal Retirement Age (SSNRA) for Injury and 5 years for Sickness.

Coverage Feature	What it Means to You
Maximum Benefit of 60% of Your Monthly Gross Income	Protect up to 60% of your paycheck.
Accidental Injury and 5-Year Sickness Coverage	You are covered in the case of a covered accident that occurs away from work or a covered sickness that causes you to be disabled.
Benefit Paid Directly to You, Regardless of Other Coverage	Use the money however best fits your financial needs, regardless of other insurance.
Waiver of Premium	Premiums are not required while you are disabled based on the length of your disability.
Age at Entry	Your premiums will be based on the date your policy becomes effective.
Return to Work Part-Time	If you return to work part time, you will receive a portion of your disability benefit in addition to your take home pay.
Affordable Premiums	Your monthly premiums could be paid with only one hour of a week's paycheck.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.
Accidental Death Benefit	A $10,000 payout will be issued if one passes due to an accident within 90 days of a Covered Disability.

This is only a summary of benefits and is subject to conditions, restrictions, and limitations. Please read plan document for further details.

Voluntary Benefits: American Fidelity (continued)

Accident Only

Whether a weekend warrior with an active lifestyle or the stay at-home type, accidents can happen anytime, anywhere, without warning. Being prepared for the unexpected can make all the difference.

American Fidelity's Accident Only Insurance policy provides you a solution for those unforeseen accidents that life sometimes delivers. Our Accident Only Insurance is designed to help pay for the unexpected medical expenses an individual may incur for the treatment of covered injuries received in an accident.

Eligibility

It is your responsibility to see the American Fidelity representative once you have satisfied the Court's waiting period.

How the Plan Works

Our Accident Only Insurance policy pays according to a wide-ranging schedule of benefits. In addition, the policy provides 24-hour coverage for accidents that occur both on and off the job. All benefits are only paid as a result of injuries received in an accident that occurs while coverage is in force. All treatment, procedures, and medical equipment must be diagnosed, recommended and treated by a physician. All benefits are paid once per covered person per covered accident unless otherwise specified in the Limitations and Exclusions section.*

Optional Accident Disability Income Rider

This rider covers you 24 hours a day and pays a monthly benefit amount when a covered person becomes totally disabled due to injuries received in a covered accident after the elimination period. The monthly benefit will be paid directly to you to use as you see fit.

Coverage Feature	What it Means to You
Plan Options	Choose the plan to meet your financial needs.
Four Choices of Coverage: Individual, Individual and Spouse, Individual and Child, or Family	Choose the coverage that fits your lifestyle.
Wide-Ranging Schedule of Benefits	Covers all types of covered injuries.
Accident Emergency Treatment Benefit	Receive a benefit when emergency treatment in a Physician's office or emergency room occurs within 72 hours of a covered accident.
Benefit Paid Directly to You, to use as you see fit	Use the benefit however best fits your financial needs.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
24-Hour Coverage	You are covered on or off the job.
Guaranteed Renewable	Keep your coverage as long as premiums are paid as required.
Additional Coverage Options	Enhance the base plan by adding an optional rider.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

* Premium and amount of Benefits may vary dependent upon Plan selected.

Limitations, exclusions and waiting periods apply. Refer to your policy for complete details. This product is inappropriate for people who are eligible for Medicaid coverage. The company has the right to change premiums by class (AO-03 Series).

Voluntary Benefits: American Fidelity (continued)

Cancer

A cancer diagnosis may be overwhelming. Even with a good medical plan, the out-of-pocket costs of cancer treatment, such as travel, childcare, and loss of income are considerable and may not be covered.

American Fidelity's Cancer Insurance can help offer financial protection so you can focus your attention on fighting cancer. We offer plans that can help assist with out-of-pocket costs often associated with a cancer diagnosis.

Eligibility

It is your responsibility to see the American Fidelity representative once you have satisfied the Court's waiting period.

How the Plan Works

Our plan is designed to help cover expenses if you are diagnosed with a covered cancer. With over 20 benefits available to you, this plan provides benefits for the treatment of cancer, transportation, hospitalization and more. We provide the money directly to you, to be used however you see fit.

Optional Riders

Enhance your base plan with the following riders:

- Critical Illness Rider. Includes a cancer benefit and a heart attack/stroke benefit.
- Hospital Intensive Care Unit Rider

Coverage Feature	What it Means to You
Plan Options	Choose the plan to meet your financial needs.
Three Choices of Coverage: Individual, Single Parent Family, or Family	Choose the coverage that fits your lifestyle.
Wide-Ranging Schedule of Benefits	Covers a wide range of treatments.
Benefit Paid Directly to You	Use the money however best fits your financial needs.
Guaranteed Renewable	Keep your coverage as long as premiums are paid as required.
Transportation and Lodging	Receive benefits if you travel more than 50 miles from your home using the most direct route for covered treatment.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Additional Coverage Options	Enhance the base plan by choosing from a selection of optional riders.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. This product is inappropriate for people who are eligible for Medicaid coverage. The company has the right to change premiums by class. The premium and amount of benefits provided vary dependent upon the plan selected.

Voluntary Benefits: Liberty Mutual

Auto Insurance

Coverage for you and your car, as well as motorcycle and specialty vehicle insurance.

Home Insurance

Coverage for your home and personal property.

Life Insurance

Coverage to meet your needs throughout life's journey.

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. This product is inappropriate for people who are eligible for Medicaid coverage. The company has the right to change premiums by class. The premium and amount of benefits provided vary dependent upon the plan selected.

Deferred Compensation

A governmental 457 (b) deferred compensation plan is a retirement savings plan that allows eligible employees to supplement any existing retirement and pension benefits by saving and investing before-tax dollars through a voluntary salary contribution. Contributions and any earnings on contributions are tax-deferred until money is withdrawn. Distributions are usually taken during retirement, when many participants are typically receiving less income and may be in a lower income tax bracket than while working. Distributions are subject to ordinary income tax. In addition to the traditional before-tax deferrals, the plan permits Roth deferrals on an after-tax basis.

The Court's Deferred Compensation program is administered by Empower Retirement Services.

Eligibility

All permanent Superior Court employees are eligible.

Contributions

Contributions are set annually by the IRS. Check with Empower or Human Resources for maximum contribution limits for 2022 plan year.

There are two different options to catch up and contribute more during the final years of your career. "Special Catch-Up" allows participants in the three years prior to normal retirement age to contribute up to double the annual contribution limit. The additional amount you may be able to contribute under the Special Catch-Up option will depend upon the amounts that you were eligible to contribute in previous years but did not.

Employees turning age 50 or older in 2022 may contribute an additional amount set by the IRS. You may not use the Special Catch-Up provision and the Age 50+ Catch-Up provision in the same year.

Rollovers

If you leave Court employment you may roll over your account balance to another 401(a), 401(k), 403(b) or an eligible governmental 457(b) plan if your new employer's plan accepts such rollovers. You may also roll over your account balance to an IRA.

Distributions

Qualifying distributions include:

- Retirement
- Permanent Disability
- Unforeseeable emergency as defined by the IRS
- Severance of employment as defined by the IRS
- Attainment of age 70½
- Death (upon which your beneficiary receives your benefits)
- Transfer to purchase service credits

Loans

Your plan allows you to borrow the lesser of $50,000 or 50% of your total account balance. The minimum loan amount is $1,000 and you have up to five years to repay your loan-up to 15 years if the money is used to purchase your primary residence.

Taxes

Contributions are taken out of your paycheck on a pre-tax basis. Distributions are taxable as ordinary income during the years in which they are distributed or made available to you or your beneficiary(ies).

Value Added Services

The following value added services are available to all employees enrolled in the corresponding carrier's coverage.

Kaiser Permanente

Video Visits

The next time you schedule an appointment at Kaiser Permanente, you may be offered a video visit with your doctor. All you need is a computer with a high-speed internet connection and a webcam or smartphone mobile device using the latest version of the KP Preventive Care App.

Advice Nurse

Get the care you need the way you want it. No matter which option you choose, your providers can see your health history, update your medical record, and give you personalized care that fits your life. Call us anytime at 866.454.8855 to make an appointment or speak to an advise nurse.

ChooseHealthy

The road to good health can take you well beyond your doctor's office. With Kaiser Permanente, you get a wide range of wellness resources. You can even pay lower fees on many non-Kaiser Permanente services designed to help you get active and stay healthy. For more information about services available through ChooseHealthy call 877.335.2746 or visit kp.org/choosehealthy.

Blue Shield of California

Teladoc

Teladoc is a new and convenient way to access quality care. U.S. board-certified doctors are available 24/7/365 to resolve many of your non-emergency medical issues through phone or video consults. Visit teladoc.com/bsc, complete the required information and click on Set up account. You can also call Teladoc at 800.835.2362.

NurseHelp 24/7

Call NurseHelp 24/7 toll-free at 877.304.0504 and talk with a registered nurse anytime you have health-related questions or visit blueshieldca.com/nursehelp for an online chat option. Experienced nurses can help you figure out how you can care for yourself, evaluate treatment options and help you determine whether to see a doctor. All at no extra charge.

LifeReferrals 24/7

Everyone can use a hand sometimes, and LifeReferrals 24/7 offers convenient support to help you meet life's challenges. A simple phone call connects you with a team of experienced professionals ready to assist you with a wide range of personal, family, and work issues. You can call LifeReferrals 24/7 toll-free at 800.985.2405. Or, visit lifereferrals.com and enter the access code: bsc.

Identity Theft Protection

As an eligible Blue Shield medical plan member, you can now get identity protection services such as identity repair assistance, identity theft insurance and credit monitoring for you and your covered family members. It makes good sense, and it's no charge. You can access these services by calling 866.274.3891 or experianidworks.com/blueshieldca. When creating your account, you will need to provide the activation code: BCBSCALI20.

Fitness Your Way

Get Healthy and feel good on your own terms with Fitness Your Way. It is a flexible, affordable, and accessible way to adopt a healthy lifestyle and remain committed it. The program offers you the flexibility to work out at any network fitness location, on your time and a budget that you can live with. Enroll by going to fitnessyourway.tivityhealth.com/bsc or by calling 833.283.8387.

Value Added Services (continued)

Cigna

Secure Travel

Emergencies can happen while traveling, but help is only a phone call away 24/7/365. Cigna Secure Travel offers pre-trip planning, assistance while traveling and emergency medical transportation benefits for covered persons traveling 100 miles or more from home. To learn more call 888.226.4567.

My Secure Advantage

Cigna knows that financial issues are one of the leading causes of stress in America.* That's why we offer a full-service financial wellness program. My Secure Advantage™ can help support the financial health of your household, at no additional cost to you. Visit cigna.mysecureadvantage.com or call 888.724.2262 for more details.

Healthy Rewards

You value your health enough to make smart choices and the Cigna Healthy Rewards program can help with discounts on a wide variety of health and wellness programs and services. No referrals. No claim forms. The Healthy Rewards program includes a nationwide network of brand name as well as smaller local participating providers. To start saving today, visit Cigna.com/rewards (**password:** savings) or call 800.258.3312.

Delta Dental

Cost Estimator Tool

Delta Dental's new online tool helps enrollees preview dental expenses. Members can generate cost estimates, review accruals toward deductibles and maximums, display cost differences between in-network and out-of-network dentists. Visit www.deltadental.com/us/en/cost-estimator.html for more information.

Magellan

Embrace lifelong wellness by taking steps toward feeling your best while improving your health and wellness. Set daily goals, track progress, read articles, and find out more information by visiting us online at magellanascend.com.

* **Stress in America™:** Coping with Change American Psychological Association, January, 2017

Important Notices

Newborns' and Mothers' Health Protection Act (NMHPA)

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

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

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 559.457.2050 for more information.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact the plan carrier directly.

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

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

Networks/Claims/Appeals

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

COBRA Continuation Coverage

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

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

NOTICE AND ELECTION PROCEDURES

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

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

ELECTION AND ELECTION PERIOD

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

Important Notices (continued)

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

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

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

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

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

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

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

IF YOU HAVE QUESTIONS

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

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

EFFECTIVE DATE OF COVERAGE

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

COST OF CONTINUATION COVERAGE

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

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

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

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

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

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

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

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

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

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

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

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

For information about Special Enrollment Rights, please contact:

Superior Court of California, County of Fresno
Human Resources
559.457.2050

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

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

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

- **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- **The Superior Court of California, County of Fresno has determined that the prescription drug coverage offered by Blue Shield of California and Kaiser Permanente are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

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

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

If you do decide to join a Medicare drug plan and drop your current Superior Court of California, County of Fresno coverage, be aware that you and your dependents will be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

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

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

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

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

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

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

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

REMEMBER

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

Date:	October 15, 2021
Name of Entity / Sender:	Superior Court of California, County of Fresno
Contact:	Human Resources
Address:	1100 Van Ness Avenue Fresno, CA 93724
Phone:	559.457.2050

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

The Superior Court of California, County of Fresno Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources at 559.457.2050.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

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

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through Covered California will begin November 1, 2021, and is anticipated to end on January 31, 2022. Open Enrollment for other states will begin on November 1 and close on December 15 of each year. Some states have expanded the open enrollment period beyond December 15, 2021 for coverage to begin in 2022. Notably, Covered California continues its special enrollment period for coverage beginning in 2021 to December 31, 2021.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.61% (for 2022) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

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

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

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

PART B: EXCHANGE APPLICATION INFORMATION

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

<table>
<tr><td>3. Employer name
Superior Court of California, County of Fresno</td><td colspan="2">4. Employer Identification Number (EIN)
77-0557392</td></tr>
<tr><td>5. Employer address
1100 Van Ness Avenue</td><td colspan="2">6. Employer phone number
559.457.2050</td></tr>
<tr><td>7. City
Fresno</td><td>8. State
CA</td><td>9. ZIP code
93724</td></tr>
<tr><td colspan="3">10. Who can we contact about employee health coverage at this job?
Human Resources Department or ADP Benefit Service Center</td></tr>
<tr><td>11. Phone number (if different from above)
ADP Benefit Service Center: 855.547.8508</td><td colspan="2">12. Email address
HR@fresno.courts.ca.gov</td></tr>
</table>

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility.

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

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866.251.4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855.MyARHIPP (855.692.7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916.445.8322
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado
Colorado's Medicaid Program & Child Health Plan Plus (CHIP+)
Healthy First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 800.221.3943
TTY: Colorado relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 800.359.1991
TTY: Colorado relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 855.692.6442

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

GEORGIA – Medicaid
Website: http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp/
Phone: 678.564.1162, ext. 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877.438.4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 800.457.4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 800.338.8366
HIPP Website:
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 888.346.9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 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: 855.459.6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 877.524.4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 888.342.6207 (Medicaid hotline) or
855.618.5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 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/info-details/masshealth-premium-assistance-pa
Phone: 800.862.4840

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: 800.657.3739

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

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

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

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

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603.271.5218
Toll-Free for the HIPP program: 800.852.3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609.631.2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800.701.0710

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

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

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

PENNSYLVANIA – Medicaid
Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 800.692.7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 855.697.4347, or 401.462.0311 (Direct RIte Share Line)

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

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

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

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

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

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp/
Medicaid Phone: 800.432.5924
CHIP Phone: 800.432.5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800.562.3022

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

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 800.362.3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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

Contact Information

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

Plan	Phone Number	Email / Website
Employee Benefits		
• ADP Benefits Center	855.547.8508	MyLifeAdvisor@adp.com
Medical		
• Kaiser Permanente	800.464.4000	kp.org
• Blue Shield		
– HMO/PPO	888.256.1915	blueshieldca.com
• Optum HSA	866.234.8913	optumbank.com
Dental		
• Delta Dental of California	800.765.6003	deltadentalins.com
• MetLife	800.880.1800	metlife.com/mybenefits Under **Access MyBenefits** type and select **Superior Court Of California, Fresno County**
Vision		
• Superior Vision	800.507.3800	superiorvision.com
Employee Assistance Program		
• Magellan Health	800.424.4039	magellanascend.com
Flexible Spending Account		
• Navia Benefits	800.669.3539	naviabenefits.com/participants
Life Insurance		
• Cigna	800.362.4462	cigna.com
Deferred Compensation		
• Empower Retirement *(Great West)*	559.967.2280	Stephanie.Henry@Empower-Retirement.com
Voluntary Plans		
• American Fidelity	405.212.2421	enroll.americanfidelity.com/E63CB2DA
• Liberty Mutual	559.512.8316	Lisa.Kiseloff@LibertyMutual.com
• Cigna Group Universal Life (GUL)	800.828.3485	cignatrustedadvisor.com/superiorcourtfresno