Employee Benefit Guide

October 1, 2024 - September 30, 2025

Benefit Plans That Fit Your Budget And Life

Carefully Designed With You In Mind

We're committed to making sure you get the benefits package that's right for both you and your family. Our package combines the peace of mind that comes with excellent medical care.

Annual Open Enrollment is your chance to ensure that your benefits package is right for you. Medical coverage, dental and vision care, and disability and life insurance options are built around you and created to keep you in great shape, physically and financially.

Please take the time to read through this booklet and understand all the options available to you. As a whole, we think we've created a benefit package that gives you outstanding support, whether you're at work, at home or even on vacation.

Table of Contents

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Selecting Your Plans

When you're first hired

Your **benefit eligibility date**, when your coverage begins, is the first day of the month following 60 days of employment. You have **30 days** following your eligibility date to submit your benefit elections, effective through September 30, 2025.

If you have a life change

Certain life events like marriage, divorce, birth or adoption of a child, or a change in employment status may allow you to change your coverage during the year. If this occurs, please contact Human Resources within **30 days** of the event to update your benefits.

During Annual Open Enrollment

Annual Open Enrollment is your opportunity once each year to evaluate your benefit options and make selections for the following year.

Benefits selected at Annual Open Enrollment are effective October 1 through September 30.

Covering your Family

Dependent eligibility

	Spouse	Children	
Medical	✓	✓	until the end of the calendar year in which they turn 30
Dental	✓	✓	until the end of the calendar year in which they turn 26
Vision	✓	✓	until the end of the calendar year in which they turn 26
Life Insurance	✓	✓	until age 30

Disabled dependents: children who became disabled before age 26 and rely on you for support are also eligible for health coverage. Please contact Human Resources if this applies to you.

Do you have your Medical Coverage elsewhere?

See page 13 for the new Pak B option for employees that have Medical coverage elsewhere, and do NOT enroll in one of the CCBOCC group Medical plan options.

Important Enrollment Instructions

2024 Open Enrollment

Important information for this upcoming Open Enrollment:

We continue to partner with U.S. Enrollment Services to assist in our Open Enrollment and have contracted for their Call Center and Co-Browsing support. **All benefit eligible employees will need to enroll in their benefits via the call center. If you DO NOT speak to a benefit specialist and enroll in benefits, your current benefits will NOT carry forward.** The benefits specialist will be trained on all benefit programs available to benefit eligible employees and will be able to answer questions regarding your programs. They will review your current elections and will assist you in making changes or modifications to benefit programs for the upcoming Plan Year. You will simply make an appointment online to set a convenient time to speak to the representative.

How to set up my appointment with a Benefits Specialist:

To schedule your appointment, go to https://columbiacountyfla.mybenefitsinfo.com or scan

Please call 800.735.0080 for assistance.

Once you schedule your appointment time, you will receive a confirmation email and a reminder email the day prior to your appointment.

Enrolling as a New Hire

When you are first hired, your coverage begins on your benefit eligibility date: the first day of the month following your 60th day of full-time employment.

The choices you make as a new hire will be in effect through September 30, 2025.

The enrollment will take place through our benefit call center with a benefit specialist.

To schedule your appointment, go to: https://columbiacountyfla.mybenefitsinfo.com or scan the above QR code with your cell phone.

Find The Medical Plan That's Best For You

Comparing Your Options

Florida Blue Medical Plans	Plan A	Plan C	Plan F / G	Plan H
	BlueChoice 0317	BlueOptions 03359	BlueOptions 05192/93 HDHP	BlueCare 60 HMO
	In- and out-of-network coverage	In- and out-of-network coverage	HDHP with HSA	In-Network Coverage Only
SINGLE COVERAGE (IF YOU COVER ONLY YOURSELF)				
Paycheck Cost	●●●●●	●●●●	●	●●●
Deductible	●●	●●●●	●●●●●	●
Out-of-Pocket Maximum	●	●●	●●●●●	●
FAMILY COVERAGE (IF YOU COVER ANY DEPENDENTS)				
Paycheck Cost	●●●●●	●●●●	●	●●●
Deductible	●●	●●●●	●●●●●	●
Out-of-Pocket Maximum	●●●	●●●	●●●●●	●

Florida Blue

Group: 15243

Website: www.floridablue.com

Phone: 800.352.2583

Download Florida Blue's mobile app for claims information, to access your ID card, find a doctor, and more!

Download on the App Store

GET IT ON Google Play

Medical Plan Coverage Summaries

	Plan A BlueChoice 0317	Plan C BlueOptions 03359
IN-NETWORK COVERAGE		
Deductible DED	$1,000 per person $2,000 family maximum	$1,500 per person $4,500 family maximum
Coinsurance (your share)	20% after deductible	20% after deductible
Out-of-Pocket Maximum	$2,000 per person $6,000 family maximum	$3,000 per person $6,000 family maximum
Preventive Care	Covered 100% in-network	Covered 100% in-network
Primary Doctor Visit	$20	$25
Specialist Doctor Visit	DED then 20%	DED then 20%
Independent Labs	20% (no deductible)	100% covered
X-Rays	DED then 20%	DED then 20%
Imaging: MRI / CT / PET	DED then 20%	DED then 20%
Urgent Care Center	$20	$65
Emergency Room	$50 then DED then 20%	$200
Inpatient Hospitalization	$150 then DED then 20%	Opt 1: DED then 20% Opt 2: DED then 25%
Ambulatory Surgery Center	DED then 20%	DED then 20%
Outpatient Hospital	DED then 20%	Opt 1: DED then 20% Opt 2: DED then 25%
OUT-OF-NETWORK COVERAGE (PLUS BALANCE BILLING)		
Deductible	Combined with In-Network	$3,000 | $9,000
Coinsurance (your share)	40% after deductible	40% after deductible
Out-of-Pocket Maximum	Combined with In-Network	$5,000 | $10,000

Pharmacy coverage		
Pharmacy Deductible	Combined with Medical DED	No Deductible
RETAIL PRESCRIPTIONS (UP TO 30 DAYS)		
Generic	Medical DED then 40%	$15
Preferred Brand	Medical DED then 40%	$30
Non-Preferred	Medical DED then 40%	$50
MAIL ORDER PRESCRIPTIONS (90 DAYS)		
Generic	$20	$40
Preferred Brand	$50	$75
Non-Preferred	$50	$125

Important terms

Copay – a flat fee you pay whenever you use certain medical services, like a doctor visit.

Deductible – the dollar amount you pay before your medical insurance begins paying deductible-eligible claims.

Coinsurance – the percentage of covered medical expenses you continue to pay after you've met your deductible and before you reach your out of pocket maximum.

Out of pocket maximum – the most you will pay during the **calendar year** for covered expenses. This includes copays, deductibles, coinsurance, and prescription drugs.

Balance billing – the amount you are billed to make up the difference between what your out-of-network provider charges and what insurance reimburses. **This amount is in addition to, and does not count toward your out-of-pocket maximum.**

Medical Plan Coverage Summaries

	Plan F / G	Plan H
	BlueOptions 05192/93 HDHP	BlueCare 60 HMO
IN-NETWORK COVERAGE		
Deductible DED	$2,500 single coverage $5,000 family coverage	$500 per person $1,000 family maximum
Coinsurance (your share)	20% after deductible	10% after deductible
Out-of-Pocket Maximum	$5,800 single coverage $11,600 family coverage	$3,500 per person $7,000 family maximum
Preventive Care	Covered 100% in-network	Covered 100% in-network
Primary Doctor Visit	DED then 20%	$25
Specialist Doctor Visit	DED then 20%	$45
Independent Labs	DED then 20%	100% covered
X-Rays	DED then 20%	$45
Imaging: MRI / CT / PET	DED then 20%	$125 (Ind. Facility: $80)
Urgent Care Center	DED then 20%	$45
Emergency Room	DED then 20%	$100
Inpatient Hospitalization	Opt 1: DED then 20% Opt 2: DED then 25%	$325 / day (max $1,625)
Ambulatory Surgery Center	DED then 20%	$200
Outpatient Hospital	Opt 1: DED then 20% Opt 2: DED then 25%	$275
OUT-OF-NETWORK COVERAGE (PLUS BALANCE BILLING)		
Deductible	$5,000 | $10,000	Not covered
Coinsurance (your share)	40% after deductible	Not covered
Out-of-Pocket Maximum	$11,600 | $23,200	Not covered

Pharmacy coverage		
Pharmacy Deductible	Combined with Medical DED	No Deductible
RETAIL PRESCRIPTIONS (UP TO 30 DAYS)		
Generic	DED then $10	$10
Preferred Brand	DED then $30	$50
Non-Preferred	DED then $50	$80
MAIL ORDER PRESCRIPTIONS (90 DAYS)		
Generic	DED then $15	$25
Preferred Brand	DED then $50	$125
Non-Preferred	DED then $80	$200

Teladoc

Teladoc HEALTH | Florida Blue

AVAILABLE NOW

You have access to clinicians anytime, anywhere*

We've added Teladoc Health to your benefits for when you need care for non-urgent and common conditions. Now, you can access clinicians by phone or video 24/7 from wherever you are.

Our U.S. board-certified clinicians help with conditions like the flu, bronchitis, rashes, sinus infections and more.

Talk to a clinician from wherever you are—day or night

Skip the trip to the ER or urgent care

Feel better when you need to.

Visit Teladoc.com

Call 1-800-TELADOC (800-835-2362) | Download the app

*Teladoc Health is not available internationally.

Teladoc is an independent company contracted by Florida Blue to provide physician visits via phone or online video to members with non-emergent medical issues. Teladoc is only available in the U.S. Teladoc® is a trademark of Teladoc, Inc. Health insurance is offered by Florida Blue. HMO coverage is offered by Florida Blue HMO, an affiliate of Florida Blue. These companies are Independent Licensees of the Blue Cross and Blue Shield Association. We comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. For more information, visit floridablue.com/ndnotice. ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-352-2583 (TTY: 1-877-955-8773). ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-352-2583 (TTY: 1-800-955-8770). BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

150910

TM-GM-20E-F23-1_4096104_B_0623

The Health Savings Account (HSA)

Savings For When You Need Care

The HSA is a great way to handle any medical, prescription, dental, and vision expenses not covered by your insurance. You make regular contributions to your account through payroll – and the contributions are tax free.

And that's not all:

» You own the account, even if you change plans or jobs;

» Your funds roll over from year to year and any growth is tax-free;

» Any withdrawal for qualified medical expenses is tax-free.

HSA Contributions

	If You Choose Individual Coverage	If You Choose Family Coverage
2024 Annual Maximum Contribution	$4,150	$8,300
2025 Annual Maximum Contribution	$4,300	$8,550
Annual County Contribution	$1,828.80 When you enroll in Plan F/G	Does not apply

Contribution maximums assume 12 months of coverage in Plans F/G and are pro-rated on a monthly basis for coverage lasting less than 12 months. Maximums include contributions from all sources; if you are eligible for a contribution from the County, that amount is included in your total maximum contribution.

AGE 55 OR OLDER? You may contribute an extra $1,000 per year in catch-up contributions.

The HSA Advantage

Brad	Angie
Brad has an individual HSA	Angie doesn't have an HSA
He saves directly from his paycheck into his HSA	She saves for medical expenses from her paycheck
$900 ($37.50 per paycheck)	$900 ($37.50 per paycheck)
$1,828.80 added by the County (employee only coverage in Plan F/G)	County contribution does not apply
No income tax is applied	- $225 (25% federal income tax)
$2,728.80 Tax-free money to cover medical expenses	$675 Post-tax money to cover medical expenses

Please remember that you'll need to enroll in one of the HDHP with HSA plan (Plan F/G) to join our HSA. Also, you can't contribute to an HSA if you're in another medical plan (including Medicare or TRICARE) or are a dependent on someone else's tax return. In these cases, you can still enroll in the HDHP plan, but you'll need to opt out of the HSA.

Choose your own bank!

A Health Savings Account belongs to you!

Open an HSA at any bank you choose and provide your account information to payroll.

Dental Insurance

Dental Care That Makes You Smile

Dental coverage is offered through The Standard. The Standard dental PPO plan allows you to visit any licensed dentist you like, but choosing an In-Network dentist will help you make the most of your plan. When searching the provider directory, choose the Classic (PPO) option.

Quality Assurance

PPO Dentists are monitored for proper licensing, cleanliness, and safety.

No Balance Billing

You won't be charged more than the contracted rate.

No Pre-Payment

You'll pay only your portion of the bill - Standard pays your dentist directly.

Lower Prices

Through reduced fees

Benefits and Covered Services	Base Plan	Buy-Up Plan
Plan Year Deductible - waived for Orthodontia	$50 Single; $150 Family	$50 Single; $150 Family
Plan Year Benefit Maximum	$1,250 per person	$2,000 per person
Type 1: Preventive Care (no deductible)	100% Covered	100% Covered
Type 2: Basic Care (fillings, extractions)	Deductible then 20%	Deductible then 20%
Type 3: Major Care (crowns, dentures)	Deductible then 50%	Deductible then 50%
Type 4: Adult & Child Orthodontic Care	50% ($1,000 lifetime max benefit)	50% ($1,000 lifetime max benefit)

The Standard Dental

Group: 162038

Website: www.standard.com

Phone: 800.547.9515

Balance billing also applies to dental insurance. When you use a non-network provider, your dentist may charge you the difference between what your plan pays and the amount they charge. You can avoid these extra charges by using an In-Network dentist.

Vision Coverage

Focus On Your Vision

Keep your eyes healthy and your vision sharp with comprehensive vision coverage offered through The Standard. Except frames, all services are available once every 12 months; frames are available once every 24 months.

	Base Plan		Buy-Up Plan	
	In-Network (VSP Choice Network)	Out-of-Network	In-Network (VSP Choice Network)	Out-of-Network
COPAYS				
Eye Examination	$10 Copay	Up to $45 reimbursement	$10 Copay	Up to $45 reimbursement
Materials	$10 Copay	N/A	$10 Copay	N/A
GLASSES				
Lenses - Single	Covered after copay	Up to $30 reimbursement	Covered after copay	Up to $30 reimbursement
Lenses - Bifocal	Covered after copay	Up to $50 reimbursement	Covered after copay	Up to $50 reimbursement
Lenses - Trifocal	Covered after copay	Up to $65 reimbursement	Covered after copay	Up to $65 reimbursement
Frames	$130 allowance	Up to $70 reimbursement	$180 allowance	Up to $70 reimbursement
CONTACTS				
Elective Contact Lenses	$130 allowance	Up to $105 reimbursement	$180 allowance	Up to $145 reimbursement
Standard Contact Fit & Follow-up	Up to $60 allowance	N/A	15% discount	N/A
Medically Necessary Contacts	Covered in full	Up to $210 reimbursement	Covered in full	Up to $210 reimbursement

Elective contact lenses are available in lieu of glasses (lenses and/or frames). You are not eligible for glasses for 12 months after you receive elective contacts, and vice-versa.

The Standard Vision

Group: 162038

Website: www.standard.com

Phone: 800.547.9515

Paycheck Deductions

Your Semi-Monthly Cost For Coverage

We do our very best to get the most competitive prices while getting you the best possible coverage. These premiums are the amount you pay for your insurance each paycheck, 24 times a year. Remember that they come out before taxes, which lowers your taxable income.

Medical Insurance

Medical Insurance	BlueChoice 0317	BlueOptions 03559	BlueOptions 05192/93 HDHP	BlueCare 60 HMO
	Plan A	Plan C	Plan F/G	Plan H
Employee Only	$152.10	$121.45	$0*	$85.60
Employee + Family	$610.66	$554.73	$197.27	$490.23

*When you elect Plan F/G Employee Only coverage, the County will contribute $1,828.80 per year to your Health Savings Account.

Dental Coverage	Base Plan	Buy-Up Plan
Employee Only	$0.00	$3.02
Employee + 1	$13.50	$18.85
Employee + Family	$36.58	$45.14

Vision Coverage	Base Plan	Buy-Up Plan
Employee Only	$0.00	$0.34
Employee + Spouse	$2.78	$3.36
Employee + Child(ren)	$2.36	$2.96
Employee + Family	$5.14	$5.97

Pak B

NEW FOR 2024

Employees that have access to other Medical coverage and choose to waive, i.e. do NOT enroll in one of CCBOCC's group Medical plans, will be eligible to enroll in the following package of benefits at no cost. Please see chart below for payroll deductions to add dependents to your coverage if you are enrolling in Pak B.

- Buy-Up Dental
- Buy-Up Vision
- $50,000 Group Term Life
- Short-Term Disability
- AFLAC Accident Plan (See page 16 for details)

Dental Coverage - Buy-Up Plan	
Employee Only	$0
Employee + 1	$15.83
Employee + Family	$42.12

Vision Coverage - Buy-Up Plan	
Employee Only	$0
Employee + Spouse	$3.02
Employee + Child(ren)	$2.62
Employee + Family	$5.63

Accident Coverage	
Employee Only	$0
Employee + Spouse	$4.85
Employee + Child(ren)	$8.89
Employee + Family	$13.74

Employee Assistance Program

Support When You Need It

Our Employee Assistance Program (EAP), provided through "ComPsych", is a **no-cost**, confidential solution to life's challenges. They are available 24 hours a day, 7 days a week, 365 days per year and provide support, resources, and information for a wide variety of needs you or your family may have:

Confidential Emotional Support

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work - Life Solutions

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

Legal Guidance

- Divorce, adoption, family law, wills, trusts and more

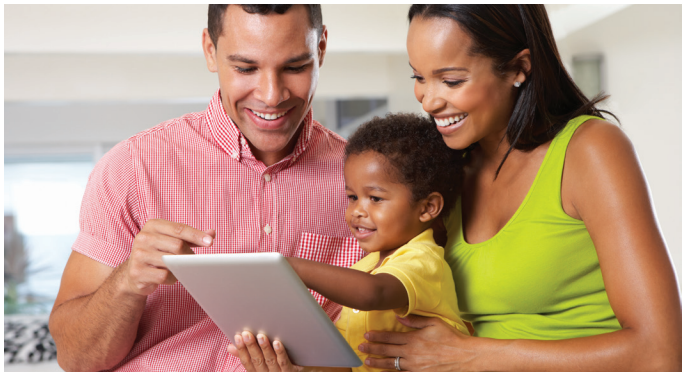
Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

Financial Resources

- Retirement planning, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy and more

Online Support

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions



ComPsych

Phone: 800.272.7255

Website: www.guidanceresources.com

Web ID: COM589

Download ComPsych's GuidanceResources® Now app to connect directly with a consultant or view articles, videos, and other information

Download on the App Store

GET IT ON Google Play

Life And Disability Insurance

Coverage For The Unexpected

Basic (County-provided) life insurance

As an employee of Columbia County Board of County Commissioners, you are provided with **$30,000** life insurance and accidental death and dismemberment (AD&D) coverage at no cost to you. Age reductions begin at age 65; please see the policy for details.

Additional life insurance coverage options

To supplement the life insurance coverage provided by the County, you have the option to purchase additional life insurance coverage for yourself and your dependents through The Standard. **You must cover yourself to cover your dependents.** Age reductions begin at age 65; please see the policy for details. Your cost for coverage depends on your age and coverage options and will be available at enrollment.

	Employee	Spouse	Child
Available increments	$10,000	$5,000	$1,000
Coverage maximum	$300,000	100% of employee amount up to $150,000	$10,000
New hire medical question maximum*	$150,000	$30,000	Not applicable

*As a newly eligible employee, you may elect up to the medical question limit with no medical questions required. Any requests to enroll or increase coverage after the first opportunity will be subject to medical questions.

Short-Term Disability Insurance

As an employee of Columbia County Board of County Commissioners, we provide you with **free** Short-Term Disability Insurance through The Standard to protect your income if you're unable to work due to an injury or illness.

When benefits begin	On the **first day** of inability to work due to an injury; or after the **7th** day due to an illness
How much it pays	60% of your income before you became disabled up to $250 per week
How long benefits last	Up to **26 weeks** if you remain unable to work

The Standard

Group: 162038

Life Insurance: 800.628.8600

Disability Insurance: 800.368.2859

Additional Benefit Options

Extra protection for you and your family

We offer additional benefit options through Aflac to provide you and your family with the protection you need. Below is a summary of the plans available.

Short-Term Disability

Short-Term Disability insurance is designed to provide you with income protection if you are unable to work due to sickness or injury.

- Benefits begin on the 1st day you are out due to an accident and on the 8th day you are out due to sickness or illness.
- 3 Month Benefit Duration
- You may elect up to 60% of your salary, up to a maximum of $3,000 per month
- Coverage is guaranteed issue, meaning no medical questions are asked at time of enrollment
- Pre-existing condition limitation – if you have had an injury or been diagnosed with an illness in the last 12 months, that specific injury or illness would not be covered for the first 12 months of this policy
- Mental Illness, drug addiction and alcoholism are excluded

Accident Insurance

This coverage is designed to help you with the cost of an accident. Benefits are paid based on the injuries received and treatment associated with a covered accident. This could be a severe burn, broken bone, emergency room visit, follow up care, and more.

- Family coverage available.
- Hospital, transportation, x-rays, and injury benefits available. Examples Include:
- Emergency Room or Urgent Care - $175
- Ambulance - $400
- Fracture / Broken Bones – Up to $6,000
- Hospital Admission - $1,000
- Wellness benefit: $50 once per calendar year

Critical Illness

Critical Illness Insurance may help you cover expenses not covered by your health insurance. It's a cash payment you receive if you ever experience a serious illness like cancer, a heart attack, or a stroke, giving you the financial support to focus on recovery. You can use the benefits however you please, such as for medical bills, medical appliances, your mortgage, or time off work.

You choose the level of coverage with benefit amounts up to $20,000.

- This coverage is guaranteed issue (no medical underwriting)
- Your spouse and children may be covered at 50% of your benefit amount

Benefits

100% of the benefit amount chosen is paid directly to you when you are diagnosed with the following critical illnesses:

- Cancer •Heart Attack •Stroke •Major Organ Transplant •Kidney Failure (End Stage Renal Failure) •Bone Marrow Transplant •Type 1 Diabetes •Sudden Cardiac Arrest •Coronary Artery Bypass Surgery
- Other illness may also be covered at a lower percentage
- Wellness benefit: $50 per insured per calendar year

Hospital Indemnity Plan

Hospital Indemnity insurance works to complement medical coverage and pays in addition to what the medical plan may or may not cover.

- Pays you if you are admitted to the hospital for any reason- sickness, injury, pregnancy
- Hospital Admission (per confinement) - $1,000
- Once per covered sickness or accident per calendar year
- Hospital Confinement (per day) - $150
- Maximum confinement period: 31 days per covered sickness or covered accident
- Hospital Intensive Care (per day) - $150
- Maximum confinement period: 10 days per covered sickness or covered accident
- Intermediate Intensive Care Step-Down Unit (per day) - $75
- Maximum confinement period: 10 days per covered sickness or covered accident
- Coverage is Guaranteed Issue
- Spouse and/or children may also be covered
- Benefits are paid regardless of other coverage
- Benefits are paid directly to you

Disclosures And Notices

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 January 31, 2024. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.mycohibi.com/ HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.967.4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kynect.ky.gov | 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 711| Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739

MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid and CHIP
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075
PENNSYLVANIA – Medicaid and CHIP
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program 800.440.0493

UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access 800.250.8427
VIRGINIA – Medicaid and CHIP
https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid and CHIP
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
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

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

Patient Protection Notices

(As provided under the Patient Protection and Affordable Care Act)

The disclosure is applicable to the following plan(s)

» BlueCare Plan 60

Designation of Primary Care Providers:

Florida Blue generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Florida Blue designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Florida Blue at 800.352.2583 or www.floridablue.com.

Designation of Pediatricians as Primary Care Providers:

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

Access to OBGYN without Referrals:

You do not need prior authorization from Florida Blue 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 Florida Blue at 800.352.2583.

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan.

However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

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

Notification of Rights under the Women's Health & 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, contact your Human Resources Department.

Newborn's and Mother's Health Protection Act

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

Notes

Notes

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

DCN24BGCC