



2024 Benefits



Here's some important information you should know.

Nonstop Health

Health Net HMO and PPO medical plans offered in 2023 will be wrapped with a section 105 medical expense reimbursement plan (MERP) around a high deductible plan (HDHP) which will be administered through Nonstop Health. We will provide you with a Nonstop visa card to help cover those out of pocket costs associated with having a HDHP, up to the allowed amount of \$9,100 (HMO) / \$6,000 (PPO) for employee plans and \$18,200 (HMO) / \$12,000 (PPO) for employee + dependent plans.

The Nonstop Health program is relatively easy to use so long as you follow these three “golden rules”:

- Stay in network for all services and prescriptions
- Use your Nonstop visa card to help pay for covered expenses up to the allowed amount for your plan
- Give Nonstop Health a call if you have any questions or run into any issues
 - 877-626-6057 | clientsupport@nonstophealth.com

Medicare Part D Notice

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices at the end of this document for more details.

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

A list of plan contacts is included at the back of this guide.

The benefits in this summary are effective

01/01/2023 through 12/31/2023



Welcome to your 2023 benefits. Our benefits program provides you with the best in coverage that is simple and easy to use. We offer programs that protect your health, your money, your family, and help you find balance between your concerns at work and at home. We also know the value of understanding your coverage so you know how to get care, when you need it, at the lowest cost. With the information and tools in this guide and related resources, we hope to help you be well today and work toward a healthy and secure future.

Inside this guide

Who is eligible for benefits?..... 4

 Employees 4

 Eligible dependents 4

 When you can enroll 4

 Changing your benefits 4

Which plan is right for you? 7

Provider Search Instructions 9

Nonstop Health 11

Dental 16

Vision 18

Life and AD&D 19

 Company-provided coverage 19

 Voluntary coverage 19

Voluntary benefits..... 20

Cost of coverage..... 21

Plan contacts 22

Determining eligibility 23

Important plan notices & documents 24



Who is eligible for benefits?

Employees

You are eligible for benefits if you are a full-time employee working 30 or more hours per week.

IMPORTANT: Employees with variable hours and seasonal schedules may be considered eligible if they work on average 30 hours a week or 130 hours a month. ProTec Building Services measures hours worked **based on the number of hours you work each month** as required by the Affordable Care Act (ACA). Refer to Determining Eligibility later in this guide for details.

Eligible dependents

- Legally married spouse or domestic partner (including same-sex spouse)
- Natural, adopted, or step children up to age 26
- Tax dependents over age 26 who are disabled and dependent on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law

Family members such as parents, grandparents and siblings who are not your tax dependents as described above are not eligible for coverage. In addition, an employee of ProTec Building Services cannot be covered as both an employee and a dependent of another employee (for example, a spouse).

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period.

New hire coverage begins on the first of the month following 60 days of employment as long as you enroll within 30 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason).

Changing your benefits

Outside of open enrollment, you may be able to add or remove dependents or change benefit options if you have a qualifying event in your life and submit your change within 30 days. Eligible events include:

- change in legal marital status
- change in number of dependents or dependent eligibility status
- change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- change in residence that affects access to network providers
- change in your health coverage or your spouse's coverage due to your spouse's employment
- court order requiring coverage for your child
- "special enrollment" event under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan



The Paylocity login screen features the company logo at the top left and a 'Help' link at the top right. Below the logo is a 'Welcome' message. The login form includes three input fields: 'Company ID', 'Username', and 'Password'. The 'Password' field has a 'Show' button with an eye icon. A checkbox labeled 'Remember My Username' is located below the password field. At the bottom of the form is a large orange 'Login' button.

Step 1: Log In

Login at access.paylocity.com

- Returning users: Log in with the username and password you selected. Click Reset a forgotten password.
- First time users: Click on your Registration Link in the email sent to you by your admin or Register as a new user. Create an account, and create your own username and password.

The dashboard sidebar on the left lists several options: 'Test User2', 'Action Needed' (highlighted with a red box), 'My Current Coverage', 'Enrollment History', 'Change My Coverage', 'Family Info', 'Beneficiaries', and 'Document Center'. The main content area, titled 'Action Required', shows a message: 'Your action is required to complete the events below.' It lists 'Not Started' and 'New Hire Enrollment Due: 4/14/2018 (24 day(s) remaining)'. A 'Start' button (highlighted with a red box) is located to the right of the enrollment information.

Step 2: Start Enrollments

Select **Action Needed** in the sidebar menu, This option only appears if an enrollment event is available.

After clicking **Start Your Enrollment**, you'll need to complete some personal & dependent information before moving to your benefit elections.

The plan selection screen is titled 'Who do you want to cover on this plan?'. It shows three options: 'Test User1 (Myself) Employee' (selected with a checkmark), 'Test Spouse Spouse', and 'Child User1 Child'. Below this is a 'Choose a Plan' section. The first option, 'HSA Open Access Plus Choice', is selected with a checkmark and has a cost of '\$67.46' for 'Employee Only'. The second option, 'Open Access Plus Choice', has a cost of '\$81.01' for 'Employee Only'. The third option, 'Waive Medical', is at the bottom. At the bottom right are 'Previous' and 'Continue' buttons.

Step 3: Benefit Elections

- Select the dependents to cover. The system will calculate a coverage tier and cost based on the dependents selected.
- Select the checkmark next to the appropriate **Plan** or **Waive** option
- Select **Continue**

If you do not want a benefit, click **Waive** at the bottom of the screen and select reason from the drop-down menu.



Who do you want to cover on this plan?

☒ **Test User 1 (Myself)**
Employee

☐ **Test Spouse**
Spouse

☐ **Child User 1**
Child

Choose a Plan

☒ **HSA Open Access Plus Choice** Employee Only
\$67.46

Provider: Cigna

My Estimated Costs per pay period:
 Employee Contribution: \$67.46
 Employer Contribution: \$101.78

☐ **Open Access Plus Choice** Employee Only
\$81.01

☐ **Waive Medical**

[Previous](#) [Continue](#)

Step 4: Designate Beneficiaries

If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.

✓ Success: Your enrollment is 100% complete and is pending approval.

My coverage as of **6/1/2018**

Viewing coverage as of 6/1/2018

The elections below are pending approval.

My Estimated Costs
\$193.92

[View PDF](#)

[Expand All](#)

Step 5: Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct, then click **Submit** to complete your enrollment. You can either print a summary of your elections for your records or login anytime throughout the year to view your benefits & summaries online.

TIP

If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.



You can login to review your
benefits 24/7



Medical - HMO

	SIMNSA HMO In-network only	Health Net HMO Smart Care *Benefits combined with Nonstop Health	Health Net HMO Salud y Mas *Benefits combined with Nonstop Health
Annual deductible	None	None	None
Annual out-of-pocket maximum	Individual: \$6,350 Family: \$12,700	Individual: Covered Family: Covered	Individual: Covered Family: Covered
Primary provider office visit	\$5 copay	Covered	Covered
Specialist office visit	\$5 copay	Covered	Covered
Chiropractic care (20 visits per year)	Not covered	Covered	Covered
Preventive care	No charge	No charge	No charge
Diagnostic lab and X-ray	No charge	No charge	No charge
Urgent care	\$25 copay	Covered	Covered
Emergency room	\$250 copay (copay waived if admitted)	\$100 copay (copay waived if admitted)	\$100 copay (copay waived if admitted)
Hospitalization	No charge	Covered	Covered
Outpatient surgery	No charge	Covered	Covered
PRESCRIPTION DRUGS			
Annual deductible	None	None	None
Annual out-of-pocket maximum	None	None	None
Generic	Pharmacy: \$5 copay Mail order: Not covered	Pharmacy: Covered Mail order: Covered	Pharmacy: Covered Mail order: Covered
Preferred brand	Pharmacy: \$5 copay Mail order: Not covered	Pharmacy: Covered Mail order: Covered	Pharmacy: Covered Mail order: Covered
Non-preferred brand	Pharmacy: \$5 copay Mail order: Not covered	Pharmacy: Covered Mail order: Covered	Pharmacy: Covered Mail order: Covered
Number of days' supply	Pharmacy: 30 days Mail order: Not covered	Pharmacy: Covered Mail order: Covered	Pharmacy: Covered Mail order: Covered



Medical – PPO

Heath Net PPO & Nonstop Combined

	In-Network	Out-of-Network
Annual deductible (deductibles do not cross apply)	Individual: Covered Family: Covered	Individual: Up to \$6,000 coverage of \$10,000 Family: Up to \$12,000 coverage of \$20,000
Annual out-of-pocket maximum (maximums do not cross apply)	Individual: Covered Family: Covered	Individual: Up to \$6,000 coverage of \$12,000 Family: Up to \$12,000 coverage of \$24,000
Primary provider office visit	Covered	40% after deductible
Specialist office visit	Covered	40% after deductible
Chiropractic care (20 visits per year)	Covered	40% after deductible
Preventive care	No charge	40% after deductible
Diagnostic lab and X-ray	Covered	40% after deductible
Urgent care	Covered	40% after deductible
Emergency room	\$100 copay (copay waived if admitted)	20% after deductible
Hospitalization	Covered	40% after deductible
Outpatient surgery	Covered	40% after deductible
PRESCRIPTION DRUGS		
Annual deductible	None	See SBC for out of network prescription benefits.
Annual out-of-pocket maximum	Covered	
Generic	Pharmacy / Mail Order: Covered	
Preferred brand	Pharmacy / Mail Order: Covered	
Non-preferred brand	Pharmacy / Mail Order: Covered	
Number of days' supply	Pharmacy: 30 days / Mail order: 90 days	



Provider Search: Medical, Dental, Vision

Line of coverage	Carrier	Plans	Link
Medical	Health Net	HMO – Salud HMO y mas Large Group	https://www.healthnet.com/portal/providerSearch.action
		HMO – SmartCare Network Large Group	
		PPO – Large Group	
	SIMNSA	HMO	https://www.simnsaee.net/Expediente2010/CitasOnline/proveedores/frm_proveedores.aspx
Dental	California Dental Network	A100+	https://www.caldental.net/FacilitySearch2/cdn/ca
	SIMNSA	Dental	https://www.simnsaee.net/Expediente2010/CitasOnline/proveedores/frm_proveedores.aspx
	Cigna	Total Cigna DPPO (Cigna DPPO Advantage and Cigna DPPO)	https://hcpdirectory.cigna.com/web/public/consumer/directory/search
Vision	The Standard	Choice	https://www.vsp.com/eye-doctor

What is Nonstop Health?

Nonstop Health is a type of healthcare program that allows organizations to fund a portion of their employees' healthcare premiums and out-of-pocket expenses (e.g. deductibles, copays, and coinsurance) while also saving on premium expenses annually. The Nonstop Health program combines an ACA-compliant health plan with a section 105 medical expense reimbursement plan (MERP) – and provides you, the member, with a Visa card to help pay for covered, carrier-approved medical expenses, up to the allowed amount of \$6,000 for employee plans and \$12,000 for employee + dependent plans.

With Nonstop Health, you will receive two cards in the mail after you enroll: your carrier identification card from Health Net and your Nonstop Visa card from Nonstop Administration and Insurance Services, Inc. (Nonstop).

What should I do with each card?

CARRIER CARD



The carrier card comes from Health Net, and includes information relevant to the HDHP.

You must present the carrier ID card from Health Net during every doctor visit and for prescription purchases. This is important to ensure that Health Net is apprised of the charge and properly credits your services towards your deductible/out-of-pocket maximum.

NONSTOP VISA CARD



The Nonstop Visa card comes from Nonstop and can be used to pay for covered, carrier-approved medical services and prescriptions, up to the allowed amount for your plan. You cannot use the Nonstop Visa card to purchase over the counter drugs.

You will receive two Nonstop Visa cards and they will both only be in your name. If you need additional cards, please call us at 1-877-626-6057. We recommend that you DO NOT set up a PIN as this will only allow you to use the card as a debit card and not a credit card.

How to access Nonstop Health without a Visa card

While Nonstop makes every effort to get you your Nonstop Visa card as quickly as possible, there are times when you may not have it in hand on the first day of coverage. Additionally, if you lose your Nonstop Visa card or it is stolen, it may take a few weeks for your new one to arrive.

But not to worry! As long as you are enrolled in Nonstop Health, you can still access all of the benefits of the program - even if you don't have your Nonstop Visa card available. Let's review how to do this for both covered medical expenses and prescriptions.



Prescriptions

If you need to pick up a prescription between and do not have your Nonstop Visa card, you have two options:

1. You can pay for that prescription out-of-pocket and be reimbursed by Nonstop. For information on submitting a claim, please visit www.nonstophealth.com/claims.
2. If your prescription is not urgent and the cost is more than you are comfortable paying out-of-pocket, you can also submit your prescription and documentation of the cost to Nonstop Health. We can then send you a check for the cost of the prescription and deduct that amount from your Nonstop Health account. Please know that it may take 7-10 business days for you to receive this check!



Medical Services

If you receive medical services before receiving your Nonstop Visa card in the mail, please request that your provider bill you for those services. Typically bills can take 30-60 days to move through the medical insurance carrier and provider systems. As such, you should have your Nonstop Visa card by the time you receive the bill.

Alternatively, you can request that your provider bill Nonstop directly! Contact us and we can send you a letter/form that explains this process to your provider.

If you need to pay a copay or coinsurance at the point of service, you will need to pay for those costs out-of-pocket and submit a claim to be reimbursed by Nonstop Health. For information on submitting a claim, please visit www.nonstophealth.com/claims.



Quick Tip! For both medical services and prescriptions, make sure you provide your medical plan information to the pharmacy or provider so all costs are applied to your deductible and out-of-pocket maximum! This is an important step in the process.

What is/isn't covered under Nonstop Health

The Nonstop Health program only works for covered services and prescriptions. But what exactly does this mean?

Key terms

Let's start by reviewing key terms that you'll read, see or hear about with Nonstop Health.



Covered prescriptions: Your carrier will set a "formulary" or drug list at the beginning of each plan year, which lists what prescriptions will be covered under your medical plan. Just because a doctor prescribes you a medication doesn't mean it's automatically covered by your carrier! So before paying for a new prescription, be sure to call your carrier or ask your pharmacist if it's covered.



Covered services: A covered service is one that your carrier has agreed to pay for under your medical plan. Not all services are covered by every plan, so before receiving a new service please check with your carrier first. Your carrier may have a cost or visit limit for specified services, or other limitations.

Examples of what Nonstop Health covers – and what It doesn't

COVERED EXPENSES

Nonstop Health can be used to pay for all services and prescriptions that are covered under your medical plan. In essence this means that if your medical carrier has agreed to pay for a medical service or prescription as part of your medical coverage, then you can use your Nonstop Visa card to pay for it. If your carrier does not cover a service or prescription, then you will be responsible for 100% of those costs. If you're not sure if a service or prescription is covered, check your Summary of Benefits and Coverage (SBC) or contact your carrier before receiving care.

NON-COVERED EXPENSES

Because medical plans cover services and prescriptions differently, there's not an exhaustive list of where you can/can't use your Nonstop Visa card. **But below are a few examples of services/providers/facilities that are never covered by Nonstop Health.** This is only a sample – if you are not sure if a service or prescription is covered, please check with your carrier!

- Amazon.com or any FSA/HSA stores
- Weight Loss Programs
- FullScripts
- FreeSpira
- Massage Envy
- Carex
- Smile Direct Club
- PeopleCare
- Warby Parker
- Hero Health

As a general rule the Nonstop Visa card cannot be used for the following:

- Over the counter medication, vitamins or supplements
- Dental services, unless covered under your medical plan
- Vision services, unless covered under your medical plan
- Services and medications not approved by your carrier
- Durable Medical Equipment (DME) that is not approved by your carrier
- Alternative care that is not approved by your carrier
- Mental health services not approved by your carrier
- Feminine hygiene products

How to find and read your EOB

An Explanation of Benefits (EOB) is a statement generated by your health insurance company summarizing how it processed a claim from a doctor, hospital, or other medical provider. **This is the most critical piece of paperwork that Nonstop will need to substantiate a charge on your Visa card or process a claim for reimbursement or provider payment! We cannot do either without an EOB.**

Your medical insurance is required to provide you with an EOB for each medical service that you receive under your insurance plan. Most health insurance companies mail EOBs to your home, although you can opt out of receiving paper EOBs and instead sign up for an online account with Health Net to access your documents digitally. Each health insurance company has slightly different approaches to EOB delivery so if you aren't sure where to find your EOBs, contact Health Net directly.

The below example shows what an EOB may look like (*actual format varies*) and what information will be provided:

**ABC Health Insurance, Inc.**

EXPLANATION OF BENEFITS
THIS IS NOT A BILL

Patricia Doe
1234 State Street
Middletown, OR 12345

Subscriber Information
Member ID: XYZ1234567890
Group ID: 123456
Group Name: Benefits Plus

5
Patient Name: Patricia Doe
Place of Service: Outpatient
Date Received: 01/01/2022

Claim Number: 01122334455Z
Type of Service: Medical
Date Processed: 02/01/2022

Provider: ER & Hospital
Payment to: ER & Hospital

ClaimDetail			What your provider can charge you		Your responsibility			Total Claim Cost		
1 Date of Service	2 Service Description	3 Claim Status	4 Provider Charges	5 Covered Charges	6 Copay	7 Deductible	8 Co-Insurance	9 Paid by Insurer	10 What You Owe	11 Remark Code
01/01/2022	Office Visit	Paid	\$\$\$	\$\$\$	\$\$\$	\$\$\$	\$\$\$	\$\$\$	\$\$\$	A12
01/01/2022	Lab	Paid	\$\$\$	\$\$\$	\$\$\$	\$\$\$	\$\$\$	\$\$\$	\$\$\$	B23
Claim Total			\$\$\$	\$\$\$	\$\$\$	\$\$\$	\$\$\$	\$\$\$	\$\$\$	

- 1. Service Description** is a description of the health care services you received, like a medical visit, lab tests, screenings, surgery or lab tests.
- 2. Provider Charges** is the amount your provider bills for your visit.
- 3. Allowed Charges** is the amount that your provider will be reimbursed, negotiated between the carrier and the provider (this may not be the same as the Provider Charges).
- 4. Paid by Insurer** is the amount your insurance plan will pay to your provider.

- 5. Payee** is the person who will receive any reimbursement for over-paying the claim.
- 6. What You Owe** is the amount the patient or insurance plan member owes after your insurer has paid. You may have already paid part of this amount, and payments made directly to your provider may not be subtracted from this amount. Wait to receive a bill from your provider before paying for the services.
- 7. Remark Code** is a note from the insurance plan that explains more about the costs, charges, and paid amounts for your visit.

HELPFUL TIP

It's a good idea to have an online account with your insurance carrier so you can access EOBs, look up providers, review plan benefits/coverage and more. If you need help setting up your account, logging in or finding your information, contact your carrier.

What information Nonstop needs from your EOB:

Nonstop needs the information/dollar amounts listed as "your responsibility" on your EOB; this includes: in-network deductible, copays, and coinsurance. Before sending us an EOB, please make sure this information is accurate and matches your provider bill. In addition, we will be looking at the remarks or comments section to confirm that the service was covered under your plan and received at an in-network provider.

Nonstop is not affiliated with your insurance carrier. This, in addition to HIPAA privacy laws, means that we cannot request EOBs or any other documents on your behalf. We can, however, participate in three-way calls with your carrier if you need help requesting an EOB for a particular service.



Prescription drug savings

Are prescription drug costs breaking your budget?

A little research before you go to the pharmacy could result in huge savings. This is especially important in a high deductible health plan because you pay the full cost of prescription drugs until you meet your deductible.

Insider tip



Your medical plan includes prescription drug coverage. You pay a different amount depending on the “tier” or class of drug.



A FORMULARY is a list of drugs that are preferred by the plan. Plans use formularies to encourage the most cost-effective drugs.



A PARTICIPATING PHARMACY (one that contracts with your medical plan) will usually offer the best price. You can find a participating (in-network) pharmacy on your plan’s website or by calling member services.



SPECIAL HANDLING REQUIRED? Your plan may require preauthorization (plan approval) or step therapy (trying certain drugs before others). Specialty drugs such as injectables may need to be purchased from a certain provider.



You can get medicines that you take routinely by MAIL ORDER. Your doctor will need to authorize a 90-day supply. You can submit refills through a website or app, or by phone.

Rx expert!

GENERIC drugs are always the least expensive. Get in the habit of asking your doctor or pharmacist if there’s a generic alternative.

If a generic drug is not available, ask your doctor whether there is an effective brand name medication that is on the plan’s preferred drug list.

SHOP AROUND! Even within the same drugstore chain, you may find a better price at a different location. Your medical plan may have an online tool or app to compare prices. Or try websites like [goodrx.com](https://www.goodrx.com) or [lowestmed.com](https://www.lowestmed.com)

Talk with your doctor about your course of treatment and confirm whether your plan requires any special procedures. Before filling your prescription, verify that the pharmacy is in-network.

Compare your plan’s mail-order copay and shipping costs against your local pharmacy price and/or other discount programs. If it’s less expensive locally, ask if your doctor can write a 90-day prescription rather than a 30-day one.



Preventive care & you

Your body doesn't come with an owner's manual, but you have to take care of it to make sure it will keep running for a long time. An important part of self-care is getting preventive medical exams to check that you're staying healthy or to identify and treat diseases before they become serious.

WHAT IS PREVENTIVE CARE?

TESTS

Blood pressure
Diabetes
Cholesterol



CHECKUPS

Well baby
Well child
Well woman



Mammograms
Colonoscopies

CANCER SCREENINGS



Prenatal care for
healthy pregnancy &
healthy baby

PREGNANCY

VACCINATIONS

Flu, pneumonia, measles,
polio, meningitis, and
other diseases



Screenings for
sexually transmitted
infections

STD

TALK WITH YOUR DOCTOR ABOUT



Tobacco use, healthy weight,
exercise, eating habits, alcohol
use, depression

FOR MORE RESOURCES, VISIT [CDC.GOV/PREVENTION](https://www.cdc.gov/prevention)



Recommended preventive care and healthy
lifestyle choices are key steps to good
health and well-being.

Prevention is a habit

- Make healthy lifestyle choices —food, exercise, sleep, safety.
- Schedule an annual physical with your primary care doctor, and follow your doctor's recommendations.
- Set health and wellness goals and work towards them daily.

Know your numbers

Keep a record of your health screening dates and results so you can talk to your doctor about any changes.

- Date of last checkup
- Height and weight
- Blood pressure
- Cholesterol
- Immunizations and vaccines
- Other test results

What preventive care do you need?

Visit [healthfinder.gov](https://www.healthfinder.gov) and enter your age and sex in the app to get a list of recommended preventive screenings for your stage in life. Talk to your doctor about which are appropriate for you.

myhealthfinder

See which preventive services you or a loved one may need this year.

Age:

Sex: ☐ Female ☐ Male

[Get Results](#)



Dental – HMO

Dental coverage provides periodic preventive care, and if there's a problem, helps with the cost of dental work.

	California Dental HMO In-network only	SIMNSA Dental HMO In-network only
Annual deductible	Individual: None Family: None	Individual: None Family: None
Annual plan maximum	Individual: None Family: None	Individual: None Family: None
Diagnostic and preventive	No charge (deductible waived)	No charge (deductible waived)
Basic services		
Fillings (2750)	\$0 - \$120 copay	\$5 - \$37 copay
Root canals (3310-3330)	\$75 - \$200 copay	\$30 - \$50 copay
Periodontics	\$20 - \$300 copay	\$7 - \$36 copay
Orthodontia services		
Orthodontia (8670)	Adolescent: \$1,775 copay Adult: \$1,975 copay	Adolescent: \$50 copay per visit Adult: \$50 copay per visit
Dependent children	Covered	Covered
Adults and eligible full-time students	Covered	Covered
Lifetime maximum	N/A	N/A

The list above is only a summary of the benefits listed. For more information on cost and copays, please refer to the benefit summary.



Dental – PPO

	Cigna Dental PPO	
	In-network	Out-of-Network*
Annual deductible	Individual: \$50 Family: \$150	Individual: \$100 Family: \$300
Annual plan maximum (Combined with out-of-network)	\$1,000 per individual	\$1,000 per individual
Diagnostic and preventive	No charge	You pay 20%
Basic services		
Fillings	You pay 10% after deductible	You pay 20% after deductible
Root canals	You pay 10% after deductible	You pay 20% after deductible
Periodontics	You pay 10% after deductible	You pay 20% after deductible
Major services	You pay 40% after deductible	You pay 50% after deductible
Orthodontia services		
Orthodontia	You pay 50%	You pay 50%
Dependent children	Covered	Covered
Adults and eligible full-time students	Covered	Covered
Lifetime maximum	\$1,000 (combined with out-of-network)	\$1,000 (combined with in-network)

**out of network coverage is paid for at the 90th percentile of submitted charges*



Vision

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

The Standard Vision PPO		
	In-network	Out-of-network
Frequency		
Examination		Every 12 months
Frames		Every 24 months
Eyeglass lenses		Every 12 months
Contacts (elective)		Every 12 months
Benefit		
Examination	\$10 copay	Reimbursement up to \$10
Materials	\$25 copay	Reimbursement up to \$25
Single vision lenses	No charge	Reimbursement up to \$30
Bifocal lenses	No charge	Reimbursement up to \$50
Trifocal lenses	No charge	Reimbursement up to \$65
Frames	Allowance up to \$150	Reimbursement up to \$75
Contacts (elective)	Allowance up to \$150	Not covered



Life and AD&D

Life insurance can fill a number of financial gaps for a family recovering from the death of a loved one. Without enough life insurance, many families have to reduce their standard of living after the loss of an income. Consider your current and future financial needs when evaluating how much coverage you need. The most common short and long-term financial needs include:

- Medical bills and funeral expenses
- Living expenses for the surviving family (housing, food, clothing, utilities, etc.)
- Large expenses, e.g., college education, or home mortgage
- Taxes and debts that need to be settled.



Make sure that you have named a beneficiary for your life insurance benefit, and update it if your family or marital status changes.

Company-provided coverage

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

The cost of coverage is paid in full by ProTec Building Services.

THE STANDARD LIFE AND AD&D

Basic Life	\$25,000
Basic AD&D	\$25,000

Voluntary coverage

Voluntary Life

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself.

THE STANDARD VOLUNTARY LIFE

Employee	Increments of \$10,000 up to \$300,000. Guaranteed issue is \$100,000
Spouse	Increments of \$5,00 up to \$150,000. Guaranteed issue is \$20,000
Child(ren)	Increments of \$2,000 up to \$10,000

If you select coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit an Evidence of Insurability (EOI) form with additional information about your health in order for the insurance company to approve this higher amount of coverage.



Voluntary benefits



ProTec Building Services offers these voluntary benefits (you pay the premium) to help you source and buy protection and services you may need for your family—at rates that may be more attractive than individual coverage. And you get the added convenience of paying through payroll deduction.

Accident insurance

Accident Insurance from Mutual of Omaha helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

If you are interested in this plan, you will find the rates via Paylocity

Critical illness insurance

Critical illness insurance from Mutual of Omaha can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Benefits can be used to help cover medical costs, transportation, child care, lost income, or costs associated with adjusting to life following a critical illness.

You choose a benefit amount that fits your paycheck. You can cover yourself and your family members if needed. If you are interested in this plan, you will find the rates via Paylocity.

Identity theft insurance

Identity theft is serious. Victims can spend hundreds, even thousands of dollars, and weeks of their own time to repair the damage done to their good names and credit records. The longer identity fraud goes undetected, the more expensive and difficult it becomes to resolve. For an affordable monthly premium, identity theft insurance from LifeLock helps protect your personal information through proactive monitoring, identity restoration, and resolution.

If you are interested in this plan, you will find the rates via Paylocity



Cost of coverage

The total amount that you pay for your benefits coverage depends on the plans you choose and how many dependents you cover.

Costs shown are semi-monthly (24/year):

Medical	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Health Net Salud Non SD	\$79.03	\$301.76	\$227.47	\$442.54
Health Net Salud SD	\$98.29	\$383.94	\$280.37	\$553.93
Health Net Smart Care HMO	\$97.57	\$380.86	\$278.45	\$549.77
Health Net PPO - CA	\$136.93	\$528.07	\$388.20	\$787.28
Health Net PPO - Non CA	\$114.80	\$433.82	\$327.32	\$659.26
Medical	Employee Only	Employee + One		Employee + Family
SIMNSA HMO	\$36.41	\$117.44		\$212.28
Dental	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
California Dental HMO	\$1.78	\$5.46	\$6.23	\$9.04
Cigna Dental PPO	\$5.15	\$17.65	19.72	\$33.53
Dental	Employee Only	Employee + One		Employee + Family
SIMNSA Dental HMO	\$2.69	\$7.71		\$16.00
Vision	Employee Only	Employee + Spouse	Employee + Children	Employee + Spouse
Vision Service Plan Vision Premier	\$3.63	\$6.18	\$6.53	\$9.78

Voluntary Coverages

The cost for the following plans will be located in Paylocity:

- The Standard Voluntary Life
- Mutual of Omaha Critical Illness
- Mutual of Omaha Accident
- LifeLock Identity Theft



Plan Contacts

Plan type	Provider	Phone	Website	Policy#
Medical	Health Net	(888) 926-4988	www.healthnet.com	175296
Medical	SIMNSA	(800) 556-1555	www.simnsa.com	234
Dental	California Dental Network	(877) 422-2138	www.caldental.net	3470
Dental	Cigna	(800) 244-6224	www.cigna.com	3343028
Vision	The Standard	(800) 547-9515	www.standard.com	164836
Life and AD&D	The Standard	(800) 547-9515	www.standard.com	164837
Voluntary Life	The Standard	(800) 547-9515	www.standard.com	164837
Accident	Mutual of Omaha	(800) 228-7104	www.mutualofomaha.com	
Critical Illness	Mutual of Omaha	(800) 228-7104	www.mutualofomaha.com	
Identity Theft	Lifelock	(904) 354-8329	www.lifelock.com	
Client Support	Nonstop Health	(877) 626-6057	clientsupport@nonstophealth.com	
Member Support	Nonstop Health	(877) 626-6057	members.nonstophealth.com	
Substantiation	Nonstop Health	(719) 270-9845 (fax)	eob@nonstophealth.com	
Claims	Nonstop Health	(877) 463-1175 (fax)	claims@nonstophealth.com	
General Support	New City	(888) 786-5839	admin@newcityinsurance.com	



Determining eligibility

The information below explains in detail how your eligibility for healthcare coverage is determined, in accordance with the rules of the Affordable Care Act (ACA).

Monthly Measurement Method

You and your dependents are eligible for the plan if you are a full-time employee. A full-time employee is generally an employee who works on average 130 hours per month, as defined by the ACA. Hours that count toward full-time status include each hour for which an employee is paid or entitled to payment for the performance of duties for the employer, and each hour for which an employee is paid or entitled to payment for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.

ACA full-time status can affect or determine major medical benefits eligibility but is not a guarantee of benefits eligibility. ProTec Building Services uses the monthly measurement method to determine whether an employee meets this eligibility threshold.

Important plan notices & documents

Health plan notices

These notices must be provided to plan participants on an annual basis and are available in the Annual Notices document:

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

COBRA continuation coverage

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

Plan documents

Important documents for our health plan and retirement plan are available in Paylocity. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator or Human Resources 800-557-2217.

Summary Plan Descriptions

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

- ProTec Building Services Health & Welfare Plan

Summary of Benefits and Coverage

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available in Paylocity.

- SIMNSA HMO
- Health Net PPO
- Health Net SmartCare HMO
- Health Net Salud y Mas HMO

Statement of Material Modifications (SMM)

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the ProTec Building Services Group Health Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

Medicare Part D Notice

Important Notice from ProTec Building Services Health & Welfare Plan 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 ProTec Building Services and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your ProTec Building Services coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

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

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

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

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

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

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

Contact the person listed below for further information or call Jose Cortez at (619) 453-5991. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through ProTec Building Services changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	11/08/2023
Name of Entity/Sender:	ProTec Building Services / Jose Cortez
Contact-Position/Office:	Human Resource Generalist
Address:	10180 Willow Creek Road, San Diego, CA 92131
Phone Number:	(800) 557-2217

Newborns' and Mothers' Health Protection Act

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

HIPAA Notice of Special Enrollment Rights

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

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in ProTec Building Services health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

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

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for ProTec Building Services describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Jose Cortez.

Notice of Choice of Providers

The SIMNSA Health Net SmartCare HMO, and Health Net Salud y Mas HMO 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, Health Net or SIMNSA designates 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 Health Net directly to change your HMO primary care provider. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Health Net or SIMNSA 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 Health Net for more information.

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

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

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

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

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

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

ALABAMA Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA
Website: Health Insurance Premium Payment (HIPP) Program 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 (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA Medicaid
Website: https://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: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
KANSAS Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
KENTUCKY Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	
LOUISIANA	Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	
MAINE	Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740 TTY: Maine relay 711	
MASSACHUSETTS	Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	
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: 1-800-657-3739	
MISSOURI	Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	
MONTANA	Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	
NEBRASKA	Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	
NEVADA	Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	
NEW HAMPSHIRE	Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	
NEW JERSEY	Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.nifamilycare.org/index.html CHIP Phone: 1-800-701-0710	
NEW YORK	Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	
NORTH CAROLINA	Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	
NORTH DAKOTA	Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	
OKLAHOMA	Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	
OREGON	Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	
PENNSYLVANIA	Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	
RHODE ISLAND	Medicaid
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	
SOUTH CAROLINA	Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	
SOUTH DAKOTA	Medicaid and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059	
TEXAS	Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	
UTAH	Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	
VERMONT	Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	
VIRGINIA	Medicaid and CHIP
: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924	
WASHINGTON	Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	
WEST VIRGINIA	Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	
WISCONSIN	Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	
WYOMING	Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 31, 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
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

ProTec Building Services
Health Insurance Rate Sheet & Per Payroll Period Deductions
Effective: January 1, 2024 - December 31, 2024

CALIFORNIA (NON-SAN DIEGO) - Health Net - Salud Non SD HMO							
EE Only		EE + Spouse		EE + Child(ren)		EE + Family	
ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion
\$177.21	\$75.95	\$268.36	\$288.63	\$238.52	\$219.00	\$326.69	\$424.74
SAN DIEGO COUNTY - Health Net - Salud SD HMO							
EE Only		EE + Spouse		EE + Child(ren)		EE + Family	
ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion
\$219.23	\$93.36	\$335.59	\$365.46	\$294.02	\$268.46	\$405.63	\$528.89
CALIFORNIA - Health Net - SmartCare HMO							
EE Only		EE + Spouse		EE + Child(ren)		EE + Family	
ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion
\$217.65	\$93.28	\$333.07	\$362.59	\$291.97	\$266.67	\$402.68	\$525.00
CALIFORNIA - Health Net - PPO CA							
EE Only		EE + Spouse		EE + Child(ren)		EE + Family	
ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion
\$305.38	\$130.88	\$464.52	\$502.22	\$408.52	\$371.54	\$571.68	\$752.25
NATIONWIDE (NON-CALIFORNIA) - Health Net - PPO Non CA							
EE Only		EE + Spouse		EE + Child(ren)		EE + Family	
ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion
\$326.53	\$109.72	\$554.17	\$412.57	\$466.77	\$313.29	694.03	\$629.89
SAN DIEGO COUNTY - SIMNSA HMO							
EE Only		EE + 1		EE + Family			
ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion
\$84.95	\$36.41	\$119.68	\$117.44	\$160.32	\$212.28		
CALIFORNIA - California Dental Network HMO							
EE Only		EE + Spouse		EE + Child(ren)		EE + Family	
ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion
\$4.33	\$1.78	\$6.06	\$5.46	\$6.43	\$6.23	\$7.76	\$9.04
NATIONWIDE - Cigna Dental PPO							
EE Only		EE + Spouse		EE + Child(ren)		EE + Family	
ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion
\$12.37	\$5.30	\$17.88	\$18.17	\$18.80	\$20.30	\$24.89	\$34.53
SAN DIEGO COUNTY - SIMNSA Dental HMO							
EE Only		EE + 1		EE + Family			
ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion
\$6.26	\$2.69	\$8.41	\$7.71	\$11.97	\$16.00		
NATIONWIDE - Standard Vision							
EE Only		EE + Spouse		EE + Child(ren)		EE + Family	
ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion
\$0.00	\$3.63	\$0.00	\$6.18	\$0.00	\$6.53	\$0.00	\$9.78
NATIONWIDE - Group Voluntary Accident							
EE Only		EE + Spouse		EE + Child(ren)		EE + Family	
ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion
\$0.00	\$4.81	\$0.00	\$7.35	\$0.00	\$9.38	\$0.00	\$13.18
NATIONWIDE - Group Critical Illness - Custom GVCIP2							
EE Only		EE + Spouse		EE + Child(ren)		EE + Family	
ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion	ER Portion	EE Portion
\$0.00	Multiple Choices	\$0.00	Multiple Choices	\$0.00	Multiple Choices	\$0.00	Multiple Choices
NATIONWIDE - LifeLock Benefit Elite							
EE Only				EE + Family			
ER Portion		EE Portion		ER Portion		EE Portion	
\$0.00		\$4.25		\$0.00		\$8.49	

