Employee Benefits Information

BLOSSOM RIDGE
HOME HEALTH • HOSPICE

Plan Effective: October 1, 2020- September 30, 2021

Welcome Valued and Trusted Employee

Blossom Ridge Home Health Agency provides comprehensive employee benefits as part of our total compensation program.

Options in cost and plan design are intended to provide you with the opportunity to customize your benefit plan to meet your lifestyle and personal choices, while offering protection, flexibility and security to you and your family.

The decisions you make regarding your enrollment in benefits deserves your careful consideration. Your choices will be in effect for the plan year. You will be able to make changes during the plan year only in the event of an IRS qualified Family Status Change. There are many resources available to assist you in making your benefit choices and remember that there are no right or wrong selections; your primary consideration in this decision is what works best for you.

Keep in mind that this summary provides only a general overview of the benefits available to you. It does not include details of all covered expenses or exclusions and limitations. Please refer to each plan's Evidence of Coverage (EOC) booklet for the terms and conditions of coverage.

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Employer Contribution

Blossom Ridge Home Health Agency contributes toward the cost of the medical, base dental and vision plans. Blossom also makes a dollar-for-dollar contribution toward the medical FSA (match up to $1,000). You will also receive basic life insurance and access to Teladoc services at no cost to you. Voluntary short and Long term disability, accident and critical illness benefits are also available.

Eligibility

Full-time employees working a minimum of **30 hours** per week are eligible for benefits on **the first day of the month following date of hire**.

Eligible Dependents

Your legal spouse or domestic partner are eligible for medical, dental and vision benefits. Children are eligible for medical, dental and vision up to age 26 regardless of their marital, financial, or student status.

When Can You Enroll?

You can sign up for benefits at any of the following times:

- After completing initial eligibility period (new-hire or transfer to benefit eligible category)
- During the annual open enrollment period for an **October 1st** effective date.
- Within 30 days of a qualified family-status change.

If you do not enroll at the above times, you must wait for the next annual open enrollment period.

How to Enroll

You will make your benefit elections utilizing the Ease online benefit portal. Your benefits administrator will provide your login information during the open enrollment period or when you first become eligible to receive benefits. You may access this portal by visiting:
BRHHA-BDR.ease.com

Making Changes

You can make changes to certain benefit elections during the year only if you experience a qualifying life event. You can request changes that are consistent with your life event by making changes to your benefit elections within 30 days after the date of the event. Depending upon the life event, you may be required to submit documentation of the event (document must state the effective date of the event). If you do not make the changes timely, you will not be able to change your benefits until the next annual enrollment opportunity. Any new election due to a life event must be on account of and correspond with the change in status event that affects eligibility for coverage. This means that there must be a logical relationship between the event that occurs and the election change you are requesting (i.e., if you divorce, it would not be logical to increase your Healthcare FSA election). Contact the Benefits Administrator for assistance in making timely changes. Such change in status events include but not limited to:

- Your marriage, divorce, or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your work status that affects your benefits
- Change in residence or work site that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

Terminating Benefits

If you or a dependent no longer meet the plan's eligibility requirements, coverage ends on the last day of the month in which you or your dependents' status changed. You must notify the Benefits Administrator within 30 days if any of your dependents cease to be eligible for benefits.

Medical Benefits

CaliforniaChoice® Your Health. Your Choice.®

	Western Health Advantage	Western Health Advantage	Western Health Advantage	Kaiser Permanente®
	WHA Silver HMO A (Base Plan)	WHA Gold HMO B	WHA Platinum HMO A	Kaiser Silver HMO C
Benefit Overview	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Network	HMO	HMO	HMO	HMO
Calendar Year Deductible	$2,300 Individual $4,600 Family	$250 Individual $500 Family	None	$2,250 Individual $4,500 Family
Calendar Year Out-of-Pocket Limit	$7,800 Individual $15,600 Family	$7,800 Individual $15,600 Family	$4,000 Individual $8,000 Family	$7,800 Individual $15,600 Family
Outpatient Services				
Physician/Specialist Office Visits	$50	$25 / $50	$25	$50 / $85
Preventive Care/ Screening/Immunization	No Charge	No Charge	No Charge	No Charge
Diagnostic Test (X-ray, blood work)	$75 / $50	$65 / $25	No Charge	$85 / $40
Imaging (CT/PET Scans, MRI)	$350	$275	$100	$300
Outpatient Surgery (Facility fee)	Deductible then $350	$300	$100	20%
Urgent Care	Deductible then $100	$25	$50	$50
Pediatric Dental See Summary	Included	Included	Included	Included
Hospital Benefits				
Emergency Room Services	Deductible then 30%	Deductible then $250	$150	Deductible then $400
Hospital Stay (Facility Fee)	Deductible then 30%	Deductible then $600 per day (up to 5 days)	$250 per day (up to 5 days)	Deductible then 20%
Prescription Drugs				
Rx Deductible	$250 Individual $500 Family	None	None	$300 Individual $600 Family
Generic	$15	$15	$10	Deductible then $17
Brand Name	Deductible then $55	$50	$30	Deductible then $65
Non-Formulary	Deductible then $85	$80	$50	Deductible then $65
Specialty Drugs	Deductible then 30% (up to $250)	20% (up to $250)	20% (up to $250)	Deductible then 20% (up to $250)

Medical Benefits

KAISER PERMANENTE® KAISER PERMANENTE® Sutter Health Plus Your Health Plan Sutter Health Plus Your Health Plan

CaliforniaChoice® Your Health. Your Choice.®

	Kaiser Gold HMO B	Kaiser Platinum HMO A	Sutter Silver HMO B	Sutter Gold HMO B
Benefit Overview	In-Network	In-Network	In-Network	In-Network
Network	HMO	HMO	HMO	HMO
Calendar Year Deductible	$250 Individual $500 Family	None	$2,250 Individual $4,500 Family	$250 Individual $500 Family
Calendar Year Out-of-Pocket Limit	$7,800 Individual $15,600 Family	$3,000 Individual $6,000 Family	$7,800 Individual $15,600 Family	$7,800 Individual $15,600 Family
Outpatient Services				
Physician/Specialist Office Visits	$25 / $50	$10 / $20	$50 / $85	$25 / $50
Preventive Care/ Screening/Immunization	No Charge	No Charge	No Charge	No Charge
Diagnostic Test (X-ray, blood work)	$65 / $25	$40 / $20	$85 / $40	$65 / $25
Imaging (CT/PET Scans, MRI)	$275	$150	$300	$275
Outpatient Surgery (Facility fee)	$340	$300	20%	$300
Urgent Care	$25	$10	$50	$25
Pediatric Dental See Summary	Included	Included	Included	Included
Hospital Benefits				
Emergency Room Services	Deductible then $250	$200	Deductible then $400	Deductible then $250
Hospital Stay (Facility Fee)	Deductible then $600 per day (up to 5 days)	$500	Deductible then 20%	Deductible then $600 per day (up to 5 days)
Prescription Drugs				
Rx Deductible	None	None	$300 Individual $600 Family	None
Generic	$15	$5	Deductible then $17	$15
Brand Name	$50	$15	Deductible then $65	$50
Non-Formulary	$50	$15	Deductible then $90	$80
Specialty Drugs	20% (up to $250)	10% (up to $250)	Deductible then 20% (up to $250)	20% (up to $250)

Medical Benefits...

Medical Benefits

CaliforniaChoice
Your Health. Your Choice.®

	Sutter Platinum HMO A	Anthem Silver EPO A	Anthem Silver EPO B (HSA Eligible)	Anthem Gold PPO A
Benefit Overview	**In-Network**	**In-Network**	**In-Network**	**In-Network***
Network	HMO	EPO	EPO	PPO
Calendar Year Deductible	None	$2,200 Individual $4,400 Family	$2,000 Individual $2,800 Ind. in a family $4,000 Family	$500 Individual $1,500 Family
Calendar Year Out-of-Pocket Limit	$4,500 Individual $9,000 Family	$7,900 Individual $15,800 Family	$6,750 Individual $13,500 Family	$6,250 Individual $12,500 Family
Outpatient Services				
Physician/Specialist Office Visits	$15 / $30	$50 / $100	Deductible then 30%	$30 / $60
Preventive Care/ Screening/Immunization	No Charge	No Charge	No Charge	No Charge
Diagnostic Test (X-ray, blood work)	$30 / $15	$50 / $100	Deductible then 30%	$60 / $30
Imaging (CT/PET Scans, MRI)	$75	Deductible then $100 + 35%	Deductible then 30%	Deductible then $100 + 20%
Outpatient Surgery (Facility fee)	$100	Deductible then $300 + 35%	Deductible then 30%	Deductible then 20% + $250
Urgent Care	$15	$100	Deductible then 30%	$60
Pediatric Dental See Summary	Included	Included	Included	Included
Hospital Benefits				
Emergency Room Services	$150	Deductible then $300 + 35%	Deductible then 30%	Deductible then $250 + 20%
Hospital Stay (Facility Fee)	$250 per day (up to 5 days)	Deductible then 35%	Deductible then 30%	Deductible then 20% + $500
Prescription Drugs				
Rx Deductible	None	$300 Individual $600 Family	Plan Deductible Applies	$200 Individual $400 Family
Generic	$5	$20	Deductible then 30% (up to $250)	$15
Brand Name	$15	Deductible then $50	Deductible then 30% (up to $250)	$40
Non-Formulary	$25	Deductible then $90	Deductible then 30% (up to $250)	$80
Specialty Drugs	10% (up to $250)	Deductible then 30% (up to $250)	Deductible then 30% (up to $250)	30% (up to $250)

*For out-of-network benefits and detailed plan information, please review the individual plan summaries.

Health Plan Resources

Online Tools

Access your health record, find a doctor, estimate your medical costs and access special offers.

www.anthem.com/ca

Nurse Hotline: 800-224-0336

Your 24-Hour Online Access

Access to medical record, email your doctor, schedule an appointment and refill a prescription. **www.kp.org**

Nurse Hotline: 866-454-8855

Online Tools

Contact schedule and appointment or change or doctor, order ID card replacement, access your benefits or forms.

www.westernhealth.com/mywha

Nurse Hotline: 877-793-3655

My Health Online

Schedule appointments, email your doctor, review lab and most test results, access medical records.

www.myhealthonline.sutterhealth.org

Nurse Hotline: 855-836-3500

Know Your Health Plan

Health Maintenance Organization (HMO): An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in-network through your Primary Care Physician (PCP). First select a PCP. Referrals to hospitals and specialists are managed by your PCP.

Preferred Provider Organization (PPO): A PPO provides benefits within the health plan's network of doctors with the option of going out-of-network at higher costs.
PPOs do not require you to select a Primary Care Physician (PCP).

- You can self-refer to specialists and see any doctor you'd like, however your benefits are not as rich when you see out-of-network doctors. Please use in-network providers whenever possible.
- You can receive care from two levels of in-network doctors where you pay less, or go to out-of-network doctors for lower benefits.

Out-of-Pocket: The amount you have to pay out of your pocket for health care services during a particular period of time, generally, calendar year.

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

Exclusive Provider Organization (EPO): health plans are similar to Health Maintenance Organizations (HMOs) as they do not cover care outside of the plan's provider network. The plan offers a local network of doctors and specialists in your area in which you can choose from. One of the biggest perks of an EPO plan is that you do not always need a referral to see a specialist.

Coinsurance: A co-sharing agreement between you and your health plan in which you pay a set percentage of the covered costs after the deductible has been paid.

Deductible: The amount you are required to pay before your benefits become payable. Deductibles are usually an annual fixed fee. Based on your benefit plan, a deductible may apply to all services obtained or to only a portion of your benefits.

Flexible Spending Account

A Healthcare Flexible Spending Account (FSA) is a pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan or elsewhere. It's a smart, simple way to save money while keeping you and your family healthy and protected.

2020 Healthcare FSA Contribution Limit: $2,750

A Dependent Care Flexible Spending Account (DCFSA) is a pre-tax benefit account used to pay for dependent care services, such as preschool, summer day camp, before or after school programs, and child or elder daycare. A Dependent Care FSA is a smart, simple way to save money while taking care of your loved ones so that you can continue to work.

2020 Dependent Care FSA Contribution Limit: up to $5,000

***You have a 90 day grace period through December 15th to incur claims and can submit claims through December 31st. Funds not used by the end of the grace period are forfeit.**

For questions regarding the Flex Spending Account, contact Barbara Bullion at babullion10@gmail.com or 916-467-6096.

Teladoc

Teladoc is a simple new, convenient and affordable option to access quality care. All Teladoc doctors are practicing PCPs, pediatricians, and family medicine physicians. See the Teladoc flyer for additional details!

When Can I use Teladoc?

- When you need care now
- If you're considering the ER or urgent care center for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

What can I use Teladoc for?

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus infection
- And more!

A Teladoc doctor is always just a call or click away. Talk to a doctor anytime for free!

Teladoc.com
Teladoc.com/mobile
1-800-Teladoc

Dental Benefits

Benefit Overview	Base Plan	Buy –Up Plan	Non-Participating
Plan Name / Network	PPO/Traditional Preferred		
Calendar Year Deductible (Max 3 per family, waived for Preventive)	$50	$50	$50
Calendar Year Maximum	$1,500	Unlimited	$1,500 / Unlimited
Preventive and Diagnostic Care Routine oral exams, cleanings, x-rays	100%	100%	100%*
Basic Services Fillings, root canal, periodontics, Posterior composite fillings	80%	90%	80%*
Major Services Crowns, dentures, bridges	50%	60%	50%*
Orthodontics	50%	50%	50%*
Lifetime Maximum	$1,000	$1,500	$1,000 / $1,500

Note: For detailed plan information, please review the individual plan summaries.
*Out-of-network services are paid based on the 90th percentile Usual, Customary, and Reasonable charge for the geographic region.

Choosing a Dental Provider

You may obtain care from any licensed provider. However, our dental plan provides you with access to richer benefits through Preferred (PPO) dentists. Services obtained from network dentists will not be subject to “balance billing”.

If you visit a Non-Participating dentist, you may be responsible for balance billed costs if the provider’s charges exceed the plan’s maximum allowable amounts for non-participating dentists. For a directory of in-network contracted providers visit the carrier website.

Vision Benefits

Humana

Benefit Overview	In-Network	Out-of-Network
Plan Name / Network	Humana Vision 160 Insight Network	
Exam *Covered every 12 months*	$10 Copay	Up to $30
Frames *Covered every 24 months*	$160 allowance	Up to $80
Lenses *Covered every 12 months* *Single Vision* *Bifocal* *Trifocal*	$10 Copay	Up to: $25 $40 $60
Contacts in lieu of glasses *Instead of glasses* *Covered every 12 months*	$160 allowance	Up to $210

Note: For detailed plan information, please review the individual plan summaries.

Choosing a Vision Provider

You may choose any provider you wish for your vision care, but you receive the highest level of coverage when you choose a provider in network for your services.

When you visit an out-of-network provider, you will typically pay more out-of-pocket. For a directory of in-network contracted providers visit the carrier website.

Basic Life and AD&D Benefits

Humana

Life insurance provides financial protection for your family if something were to ever happen to you. Benefits can be used towards income replacement, a mortgage, tuition, outstanding debt and more.

Benefit Overview	Group Life
Eligibility	All Full-Time Employees
Benefit Amount	$15,000

Reduction of Benefits

The amount of life insurance is reduced at certain ages according to an age reduction schedule. Refer to your benefit summary for more information.

Voluntary Life Benefits

Humana

You may choose voluntary life benefits on a guarantee issue basis, no health questions, as long as you enroll when first eligible. **There is no open enrollment opportunity.**

Benefit Overview	Voluntary Life
Eligibility	All Full-Time Employees
Benefit Amount	Employee: $30,000 Spouse: $10,000 Child(ren): $10,000

Reduction of Benefits

The amount of life insurance is reduced at certain ages according to an age reduction schedule. Refer to your benefit summary for more information.

Voluntary Long Term Disability

Long term disability Insurance provides partial replacement of your current income should you suffer a disabling illness or injury and are unable to work for an extended period of time. *You plan benefits will be dependent on your annual income.*

How does it work?

This coverage pays a monthly benefit if you have a covered illness or injury and you can't work for a few months — or even longer.

You're generally considered disabled if you're unable to do important parts of your job — and your income suffers as a result.

Why is this coverage so valuable?

You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.

Benefit Overview	Earnings of more than $123K annually	Earnings of $123K or less annually
Eligibility	working 30 hours or more per week	
Benefit Amount	60% of earnings	
Maximum Monthly Benefit	The plan will pay 60% of your monthly earnings up to a maximum of $10,000 per month	
Waiting Period	Benefits are payable after **90** days of disability	Benefits are payable after **360** days of disability
Occupational Protection	2 years own occupation	
Duration of Benefit	The plan will continue to pay benefits as long as you meet the definition of disability to Social Security Normal Retirement Age	

American Fidelity Benefits

Blossom Ridge Home Health Agency enhances your benefit program by offering supplemental benefits through American Fidelity Assurance Company. You have the option to enroll in the following plans:

Short-Term Disability

Critical Illness

Accident

****For questions regarding the supplemental benefits contact: Barbara Bullion at babullion10@gmail.com or 916-467-6096.***

Section 125 Plan

Pre-Tax Eligible Plans

Your contributions towards the elected Health & Welfare Benefits are pre-tax deductions in accordance with Section 125 of the Internal Revenue Code; this will reduce your taxable income. These elections are binding and cannot be modified until the next enrollment period, unless you have a Family Status Change or Special Enrollment Event (Qualifying Event). The tax-free exemption is not available for your Domestic Partner (DP) unless she/he is an eligible “tax dependent” as defined in IRS Code §152. Premiums for dependents that fall outside of the IRS definitions must be paid post-tax.

Sample Section 125 Salary Reduction Plan			
Without Pretax Deduction		With Pretax Deduction	
Taxable Gross	$1,000.00	Gross	$1,000.00
15% Federal Tax	-$150.00	Medical & Dental	-$100.00
7.65% Social Security Tax	-$76.50	**Taxable Gross**	$900.00
4% CA Tax	-$40.00	15% Federal Tax	-$135.00
Take Home	$733.50	7.65% Social Security Tax	-$68.85
Medical & Dental	-$100.00	4% CA Tax	-$36.00
Take Home	**$633.50**	**Take Home**	**$660.15**

Important Federal Notices

Women’s Health and Cancer Rights Act of 1998

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 your plan.

Newborns’ Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits or 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).

Important Federal Notices Continued

Notice of Patients Protections

HMO plans offered through California Choice generally require 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, some HMO plans offered through California Choice will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator.

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

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

Mental Health Parity Provisions

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as copays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more information, please visit: www.cms.gov or http://www.dol.gov/ebsa/newsroom/fsmhpaea.html

Special Enrollment Notice

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 toward 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).

In addition, 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. To request special enrollment or obtain more information, contact your plan administrator.

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)**.

Michelle's Law

A group health plan or issuer shall not terminate coverage of a dependent child due to a medically necessary leave of absence that causes the child to lose student status before the date that is the earlier of:

- the date that is one year after the first day of the medically necessary leave of absence; or
- the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage. *See ERISA section 714(b).*

Important Federal Notices Continued...

Important Reference Information

CONTACT	CONTACT TYPE	WEBSITE/EMAIL	PHONE NUMBER
Blossom Ridge Home Health Agency	Benefits Administrator		800-991-6147
Karri Suchland	Human Resources	karri@blossomridge.net	
Benefits Done Right	Benefits Advisor		800-482-1817
Marilu Montero	Account Manager	mmontero@benefitsdoneright.com	ext. 220
Marina Corona	Associate Account Manager	mcorona@benefitsdoneright.com	ext. 214
CARRIER (In alphabetical order)	**PLAN**	**WEBSITE/EMAIL**	**PHONE NUMBER**
American Fidelity Assurance Company	Flexible Spending Account Supplemental Benefits	https://af.americanfidelity.com	
Barbara Bullion		babullion10@gmail.com	916-467-6096
California Choice **Group No. 50056**	Medical	www.calchoice.com	800-558-8003
Humana **Group No. 788867**	Dental Vision Group Life Voluntary Life	www.humana.com	800-233-4013
Teladoc **ID No. 146130**	Telephonic Medical	teladoc.com teladoc.com/mobile	1-800-Teladoc
UNUM **Group No. Pending**	LTD	www.unum.com	866-679-3054
Ease **Employee Benefits Portal**	**Self Service Resource**	**BRHHA-BDR.ease.com**	**Benefit Summaries, SBC's, SPD, Creditable Coverage Notice, Forms**

BDR
Benefits Done Right

A Different Approach to Employee Benefits.

Benefits Done Right

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