2026 BENEFITS

COUNTY OF TUOLUMNE

REFRESH, RENEW, RECHARGE

CONTENTS

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.

GETTING STARTED

2026 BENEFITS

January 1, 2026, through December 31, 2026

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between County of Tuolumne supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

MEDICARE PART D NOTICE

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

YOUR BENEFIT INFORMATION

We are excited to announce that we will continue to offer the same plan options in 2026. Please note that there will be increases in the medical plan costs at all levels. However, we are committed to ensuring that our plans remain competitive and minimize out-of-pocket expenses.

2026 CHANGES	
PLANS	ADDED
Anthem Blue Cross Care PPO Anthem Blue Cross Choice PPO Anthem Blue Cross Safety PPO	The Pharmacy Benefit Manager (PBM) will be transitioning from Express Scripts to Navitus. See page 16 for details.
Anthem Blue Cross Care PPO Anthem Blue Cross Choice PPO Anthem Blue Cross Safety PPO	Anthem Total Health Connections provides you and your family with a dedicated Family Advocate. See page 35 for details.
Anthem Blue Cross Care PPO Anthem Blue Cross Choice PPO Anthem Blue Cross Safety PPO	Digbi Health's Diabetes, Obesity, and GI Care program is a personalized journey designed to transform your health and wellness. See page 38 for details.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

You are eligible if you are a full-time employee working at least 64 hours per 80 hour pay period.

Eligible dependents

- Legally married with proof of marriage certificate. Registered Domestic Partner with proof of registration with the Secretary of State. Natural, adopted or stepchildren up to age 26.
- Children over age who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the benefit booklets for each benefit.

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 hire.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment in 2026 (the one time each year that you can make changes to your benefits for any reason).

CHANGING YOUR BENEFITS

Click to play video

LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- 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
- Change in an individual's eligibility for Medicare or Medicaid
- 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
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 30 days after the event.

COUNTY OF TUOLOMNE
2026 OPEN ENROLLMENT BENXCEL LOG IN INSTRUCTIONS

WELCOME TO BENXCEL!
These instructions will help you complete your Open Enrollment benefit elections for the 2026 Plan Year (January 1, 2026 – December 31, 2026) using BenXcel.

OPEN ENROLLMENT DATES
Your Open Enrollment Period to make 2026 Plan Year benefit elections/changes begins on October 1st and ends on October 17, 2025.

IMPORTANT BENEFIT INFORMATION FOR OPEN ENROLLMENT

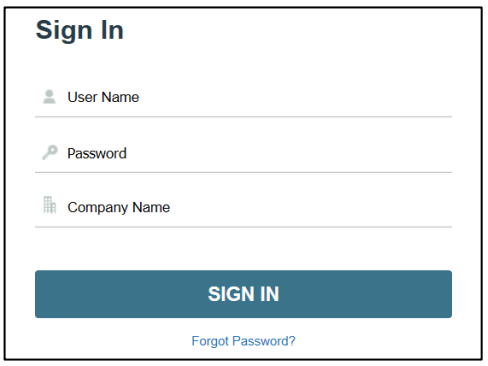
BCC CUSTOMER SERVICE CALL CENTER

CONTACT: 800-685-6100 or customersupport@benxcel.com

MON - THURS: 5:00am – 5:00pm PT | FRI: 5:00am – 3:00pm PT

BENXCEL LOG IN INSTRUCTIONS

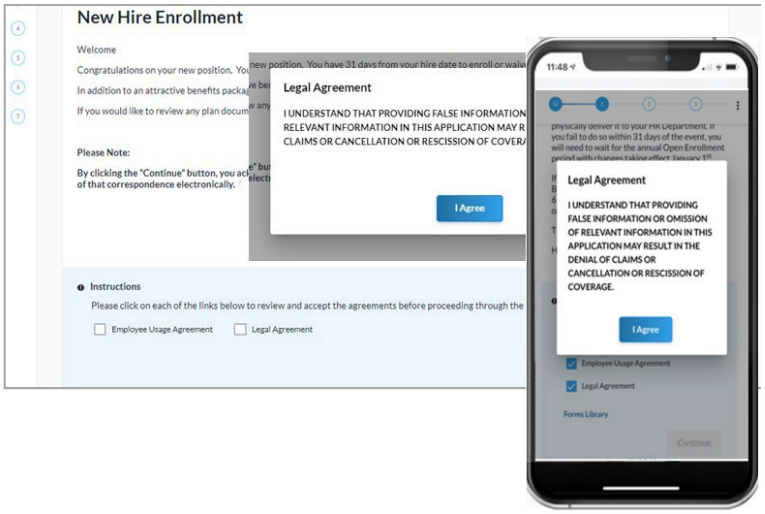
1. Go to: https://benxcel.net
2. Enter your User Name: the first 4 letters of your last name and the last 4 digits of your SSN
   → *(ex: Mickey Mouse with SSN: 123456789 would be- mous5678)*
3. Enter your Initial Password: the first 4 letters of your last name and the first 4 digits of your SSN
   → *(ex: mous1234)*
4. Enter the Company Name: County of Tuolomne
5. Click the SIGN IN button to enter the system



ENROLLMENT PROCESS

Once logged in, you will immediately enter your Open Enrollment tunnel and be required to complete your enrollment:

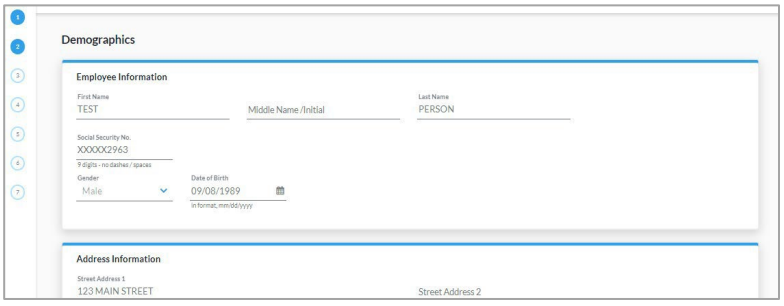
1. Review the Required Employee Usage Agreement, Legal Agreement and Welcome screens. Click CONTINUE on each of these screens to agree and proceed.



2. For security purposes, a Change Password screen will appear. You are required to change your initial password and configure two security questions/answers. Click SAVE when finished to proceed.

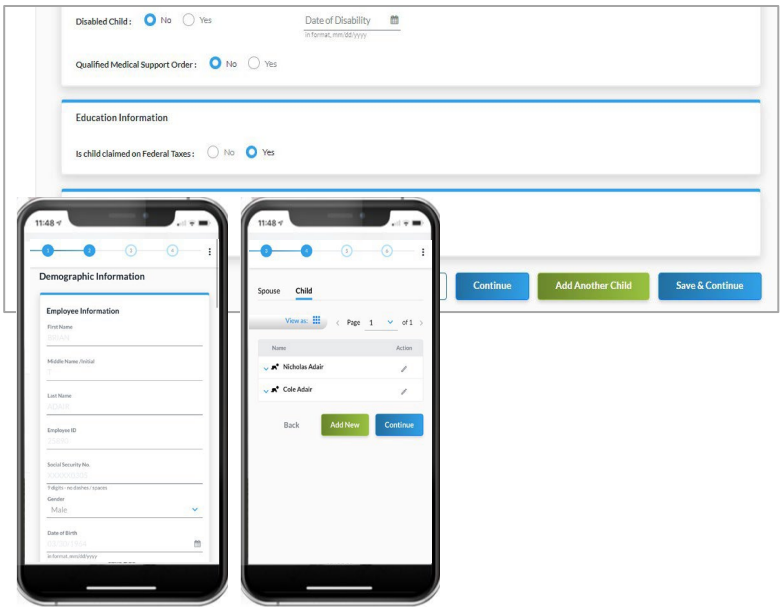
3. A Demographics screen will appear for you to review your existing information. Click SAVE to proceed.

   - *All fields marked in red are required. Any blank fields are optional. Fields shaded in grey cannot be changed. If a field in grey needs updated, please contact your HR Department.*



4. A Spouse/Domestic Partner screen and a Dependent Child screen will appear for you to add a Spouse/Domestic Partner and/or child(ren). Click CONTINUE to proceed.

   - All fields marked in red are required. Any blank fields are optional. Fields shaded in grey cannot be changed. If a field in grey needs updated, please contact your HR Department.



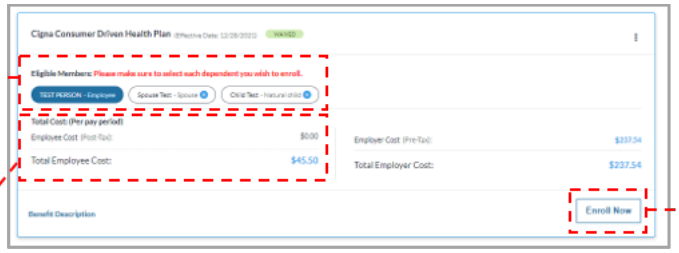
When adding a dependent spouse or child, supporting eligibility documentation must be uploaded after your enrollment is complete. See Document Upload instructions.

5. Your enrollment will begin and you will be presented with each benefit available for you to enroll:

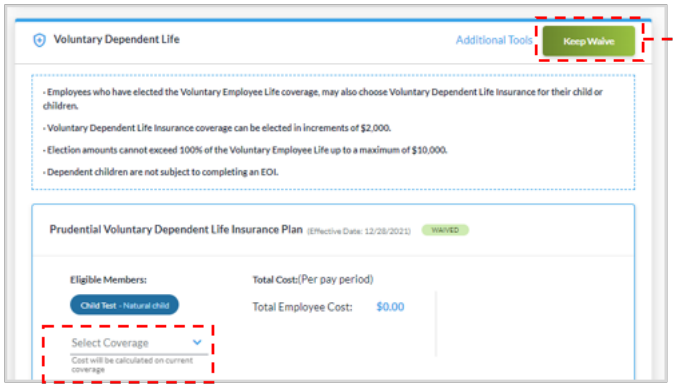
   - Additional information on the Plan may be available by clicking “Benefit Description”, “Plan Comparison”, or “Watch Video”.
   - Once you Enroll or Waive in a plan, that benefit type will ‘collapse’ to present the next benefit type. You can return and make changes to any benefit type by clicking on the blue arrows next to the benefit type name (ex: Medical, Dental, etc.)
   - If a form is required for an enrollment (i.e. Evidence of Insurability Form for Voluntary Life/AD&D), the form will appear as a pop up box with instructions for completion and submission.

If the benefit can cover your eligible dependents, use the ELIGIBLE MEMBERS section to select all individuals who should be covered.

Your cost of the Plan will change as you select or unselect the individuals to be covered.



Click ‘Enroll Now’ to select and enroll; or click ‘Keep Plan’ to retain your current enrollment.

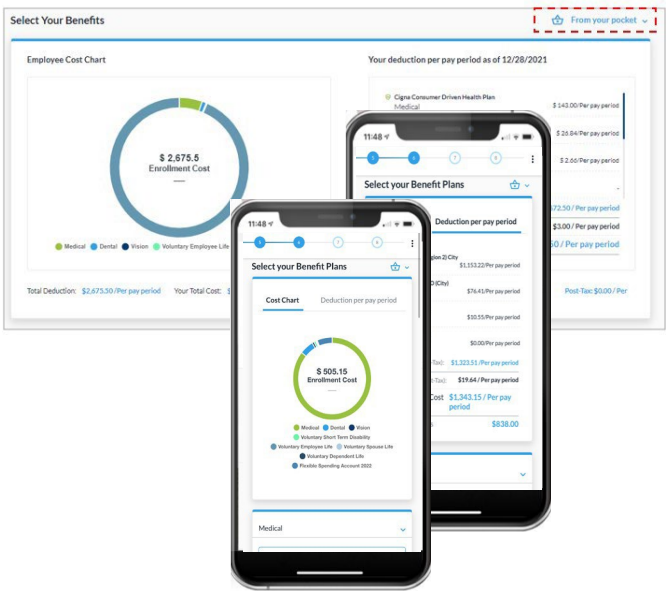


If the benefit is able to be waived, and you wish to waive it: click ‘Waive’ or ‘Keep Waive’.

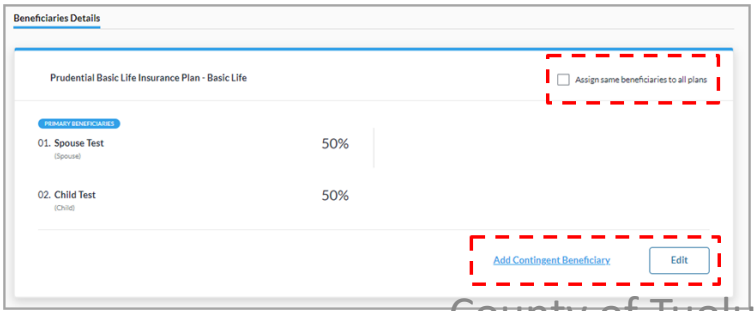
If the Plan requires you to select a COVERAGE AMOUNT, use the drop down to select your desired amount

If the Plan requires you to enter a coverage amount, type directly into the amount field.

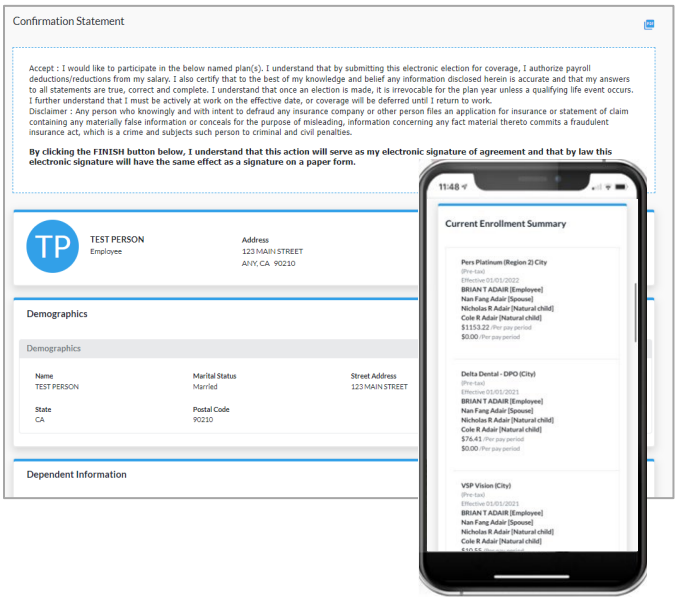
6. An ELECTION SUMMARY/FROM YOUR POCKET feature is available by clicking the link along the top of your Enrollment screen; it continually updates with your elections and costs throughout your enrollment.



7. A BENEFICIARY screen will appear if you have elected any coverages requiring you to designate a beneficiary.



8. A CONFIRMATION STATEMENT will appear when your enrollment is complete. It will show your demographic information, current benefits (enrollment summary prior to October 2022), and future elections (2022-2023 benefit elections).

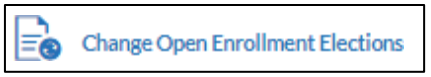


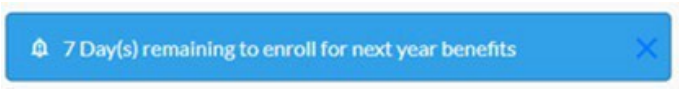
9. Click FINISH to submit your enrollment. A confirmation pop-up box will appear when your enrollment is finished processing; your dashboard will appear. Once satisfied with your elections, log out of BenXcel by clicking your name and then clicking LOG OUT at the top right corner of your screen.

If you log out of the system at any time without finishing your enrollment, the system will save all elections made prior to you logging out.

MAKING CHANGES TO YOUR OPEN ENROLLMENT ELECTIONS & ENROLLMENT COUNTDOWN

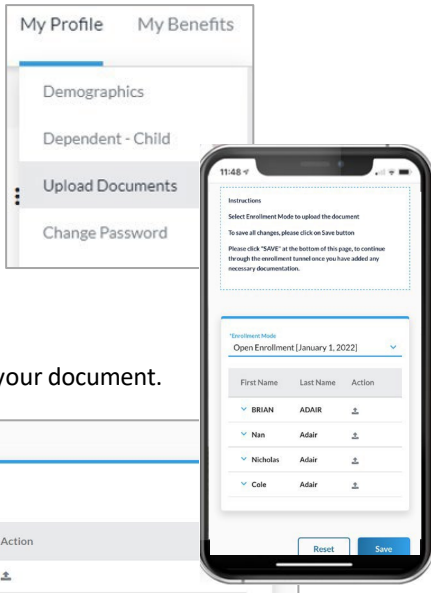
You can log back in at any time during your designated Open Enrollment period to make changes to your elections by clicking the CHANGE OPEN ENROLLMENT ELECTIONS link. A blue countdown box will also appear at the top of your dashboard, notifying you of the amount of time remaining to make benefit elections.

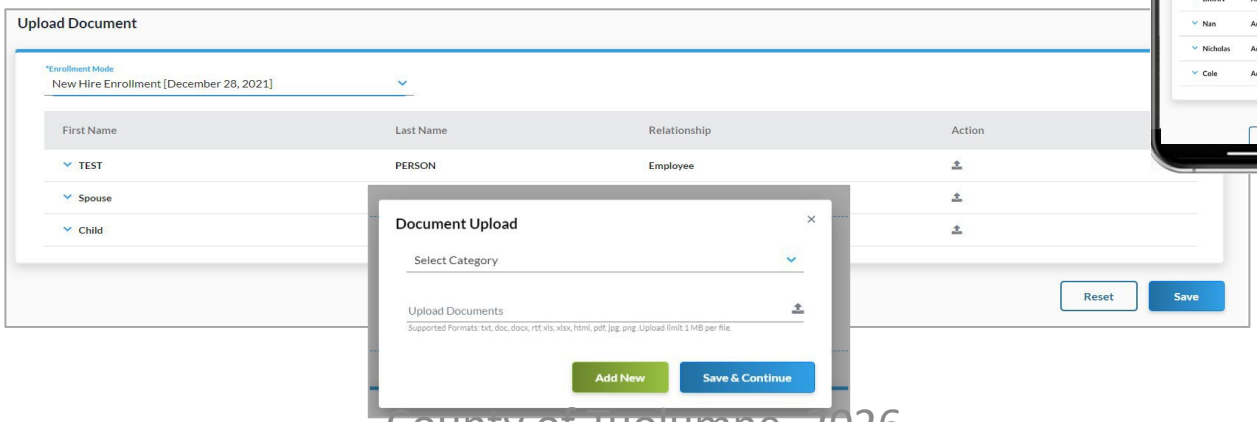




DOCUMENT UPLOAD

1. From your dashboard, use your MY PROFILE menu to select UPLOAD DOCUMENTS
2. Select your recent enrollment type from the Enrollment Mode dropdown menu.
3. In the 'Action' column for the individual in which the document applies, click the grey arrow to begin your upload. A Upload Document pop-up will appear:
   - Select Category: choose the document type from this drop down menu
   - Upload Documents: browse your computer for the document. Once the document is selected, click 'Add New' to apply the document to your profile.
   - Click 'Save & Continue' to return to the Document Upload Screen
4. When the pop-up disappears, click 'Save' at the bottom right corner of the screen to submit your document.





MEDICAL

OUR PLANS

Kaiser – Medical Traditional HMO

Anthem – PRISM Safety PPO

Anthem – PRISM Care PPO

Anthem – PRISM Choice PPO

Navitus- RX

WHICH PLAN IS RIGHT FOR YOU?

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

PPO Plans- do you prefer specific doctors or hospitals?

If you want to stay with your favorite doctors and facilities, check whether they are in the plan's network. If they are not, but you are comfortable paying a bit more to see them, consider a plan with both in-network and out-of-network benefits.

What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

KAISER – TRADITIONAL HMO

	Kaiser HMO
Annual Deductible	$0
Annual Out-of-Pocket Maximum	**Self-only Coverage:** $1,500 **Family Coverage:** each member in a family of two or more members $1,500 **Family Coverage:** entire family of two or more members $3,000
Office Visit	$15 visit; specialist $15
Online Visit	$0
Chiropractic & Acupuncture (combined 20 visits)	$15 per visit
Lab and X-ray	No charge
Urgent Care	$15 per visit
Emergency Room	$50 visit
Hospitalization	No charge
Outpatient Surgery	$15 per procedure
PRESCRIPTION DRUGS	
Supply limit	30 days
Deductible	$0
Generic	$5
Brand Name	$20
Specialty	$20
Mail Order	
Supply limit	100 days
Generic	$10
Brand Name	$40
Specialty	Not covered (available at Pharmacy)

ANTHEM SAFETY PPO

Network - Prudent Buyer	Anthem Safety PPO	
	In-Network	Out-of-Network
Annual Deductible	$300 person $900 family	$600 person $1,800 family
Annual Out-of-Pocket Maximum	$2,000 person $4,000 family	Unlimited
Office Visit	$10 copay; specialist $35 copay	20% coinsurance after medical deductible is met
Online Visit	$10 copay; specialist $35 copay	$10 copay; specialist $35 copay
Manipulation Therapy & Acupuncture (20 visits combined)	$20 copay	20% coinsurance Manipulation, 10% coinsurance Acupuncture after medical deductible is met
Lab and X-ray	20% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Urgent Care	$35 copay	20% coinsurance after medical deductible is met
Emergency Room	20% coinsurance after medical deductible is met	Covered as In-Network
Hospitalization	20% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
Outpatient Surgery	20% coinsurance after medical deductible is met	20% coinsurance after medical deductible is met
PRESCRIPTION DRUGS		
Pharmacy Name	**Navitus***	**Navitus***
Supply limit	30 days	30 days
Deductible	$0	$0
Out-of-Pocket Maximum	$2,000 Individual, $4,000 Family	$2,000 Individual, $4,000 Family
Generic	$10	$10
Preferred Brands	$25	$25
Non preferred brands	$45	$45
Mail Order		
Supply limit	90 days	90 days
Generic	$20.00	$20.00
Preferred Brands	$40.00	$40.00
Non preferred brands	$75.00	$75.00

*90-day supply for maintenance medication available through Costco.

ANTHEM CHOICE PPO

Network - Prudent Buyer	Anthem Choice PPO In-Network	Out-of-Network
Annual Deductible	$500 person $1,000 family	$500 person $1,000 family
Annual Out-of-Pocket Maximum	$3,000 person $6,000 family	Unlimited
Office Visit	$20 copay $35 specialist	40% coinsurance after medical deductible is met
Online Visit	$20 copay; $35 specialist	$20 copay; $35 specialist
Manipulation Therapy & Acupuncture (20 visits combined)	$15 copay	40% coinsurance after medical deductible is met
Lab and X-ray	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Urgent Care	$35 copay	40% coinsurance after medical deductible is met
Emergency Room (copay waived if admitted)	$50 copay per visit; doctor and other services 20% coinsurance after deductible is met	Covered as in-Network
Hospitalization	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Outpatient Surgery	20% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
PRESCRIPTION DRUGS		
Pharmacy Name	**Navitus***	**Navitus***
Supply limit	30 days	30 days
Deductible	$0	$0
Out-of-Pocket Maximum	$2,000 Individual; $4,000 Family	$2,000 Individual; $4,000 Family
Generic	$5	$5
Preferred brands	$20	$20
Non preferred brands	$50	$50
Mail Order		
Supply limit	90 days	90 days
Out-of-Pocket Maximum	$1,000	$1,000
Generic	$10	$10
Preferred brands	$40	$40
Non preferred brands	$100	$100

*90-day supply for maintenance medication available through Costco.

ANTHEM CARE PPO

Network - Prudent Buyer	Anthem Care PPO	
	In- Network	Out-of-Network
Annual Deductible	$500 person $1,000 family	$500 person $1,000 family
Annual Out-of-Pocket Maximum	$2,000 person $4,000 family	Unlimited
Office Visit	$20 copay; specialist $35	40% coinsurance after medical deductible is met
Online Visit	$20 copay; specialist $35	40% coinsurance after medical deductible is met
Manipulation Therapy & Acupuncture (20 visits combined)	$15 copay	40% coinsurance after medical deductible is met
Lab and X-ray	10% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
Urgent Care	$35 copay	40% coinsurance after medical deductible is met
Emergency Room (copay waived if admitted)	$50 copay per visit; doctor and other services 10% coinsurance after medical deductible is met.	Covered as in-Network
Hospitalization	$250 copay per admission then 10% coinsurance after medical deductible is met	$250 copay per admission then 40% coinsurance after medical deductible is met
Outpatient Surgery	10% coinsurance after medical deductible is met	40% coinsurance after medical deductible is met
PRESCRIPTION DRUGS		
Pharmacy Name	**Navitus***	**Navitus***
Supply limit	30 days	30 days
Deductible	$0	$0
Out-of-Pocket Maximum	$2,000 Individual; $4,000 family	$2,000 Individual; $4,000 family
Generic	$5	$5
Preferred brands	$20	$20
Non preferred brands	$50	$50
Mail Order		
Supply limit	90 days	90 days
Out-of-Pocket Maximum	$1,000	$1,000
Generic	$10	$10
Preferred brands	$40	$40
Non preferred brands	$100	$100

*90-day supply for maintenance medication available through Costco

NEW Anthem Prescription Drugs – Navitus

Filling Your Prescriptions

Anthem members have access to prescription drug coverage through Navitus.

- **Network Pharmacy –** Most independent and all major chain pharmacies, are part of your benefit network.
- **Costco Mail Order –** A 90-day supply of maintenance medications can be mailed right to your door. You don't need to be a Costco member to use their pharmacies. Just register online at pharmacy.costco.com or call (800) 607-6861 to get started.
- **Specialty Pharmacy -** Lumicera Health Services, our specialty pharmacy partner, provides a high level of personalized care for members with complex conditions. Their clinical team will help you manage side effects and reduce complications, so you can focus on the things that matter most. Visit lumicera.com/patients/ or call (855) 847-3553 for more information.

Member Portal & App

Go to navitus.com/members to access the member portal or download the Navitus mobile app. Register for your account, if you haven't already done so. Log into the Navitus member portal and app with the same username and password. Once registered, click Sign In, then enter your login details and password. From here you can:

- View or print your member ID card
- Perform a Drug Search for coverage details
- Find drug prices and pharmacy locations
- Easily track your medication history

Simplifying Prior Authorization, Step Therapy & Exception to Coverage

There are certain conditions and medications which require extra steps to gain approval to fill the prescription, but Navitus tries to make it as easy as possible.

- **Prior Authorization (PA) –** Some prescriptions require prior authorization to be filled, which your health care provider will need to help facilitate. Drugs that need prior authorization are listed on your formulary with a PA. Most prior authorization requests are reviewed within two business days and urgent requests within one business day.
- **Step Therapy –** When there's an effective alternative available that's less expensive for you, you may be asked to try that before a more expensive prescription is authorized.
- **Exception to Coverage (ETC) –** If a drug isn't approved, you and your doctor can submit an ETC request showing alternative medications aren't effective or suitable for your personal situation.
- **Coverage Details -** If there are any limits or requirements on your medications like the ones listed above, a Coverage Details button will appear on the medicine's description page in the portal. Clicking on that button will outline what's needed to get the prescription filled.

Navitus Customer Care

Carrier ID: NVPSM

Phone: 855-847-1035

Website: https://benefitplans.navitus.com/NVPSM

Available 24 hours a day, 7 days a week; Closed Thanksgiving & Christmas

DENTAL

OUR PLANS

Delta Dental PPO Plan - Basic

Delta Dental PPO Plan – Executive
Only available to Executive/Confidential members.

Why sign up for Dental coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers three types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures
- **Orthodontia** treatment to properly align teeth within the mouth.

Delta Dental PPO Plan - Basic

	In-Network	Out-of-Network Benefits
Annual Deductible	$25 per individual; $75 per family	$25 per individual $75 per family
Annual Plan Maximum	$1,000 per individual	$1,000 per individual
Diagnostic & Preventive	100%(deductible waived)	100% (deductible waived)
Basic Services	80% after deductible	80% after deductible
Major Services	60% after deductible	60% after deductible
Orthodontic	50% Children: Covered Adults: Covered	50% Children: Covered Adults: Covered
Ortho Lifetime Max	$1,000 Lifetime	$1,000 Lifetime

Delta Dental PPO Plan – Only available to Executive/Confidential members

	In-Network	Out-of-Network Benefits
Annual Deductible	$25 per individual; $75 per family	$25 per individual $75 per family
Annual Plan Maximum	$1,500 per individual	$1,500 per individual (combined with in-network)
Diagnostic & Preventive	100% (deductible waived)	100’% (deductible waived)
Basic Services	80% after deductible	80% after deductible
Major Services	70% after deductible	70% after deductible
Orthodontic	50% Children: Covered Adults: Covered	50% Children: Covered Adults: Covered
Ortho Lifetime Max	$1,500 Lifetime	$1,500 Lifetime

VISION

OUR PLAN

VSP Vision –Choice Plan

Click to play video

Why sign up for Vision coverage?

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

You'll even find discounts on services like LASIK, contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

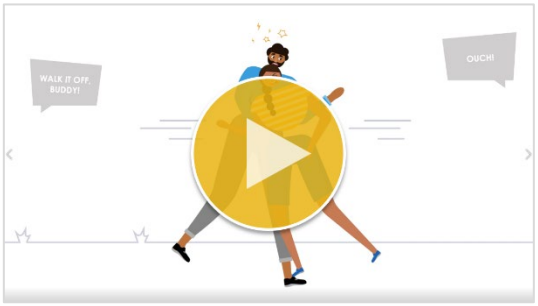
VSP Vision Plan
Network - VSP Choice

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below. Log in to vsp.com to find an in-network provider.

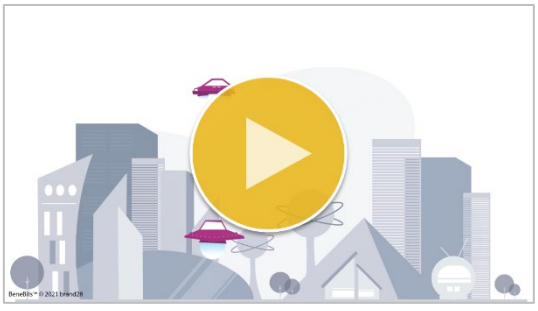
	In-Network	Out-of-Network
Copay	Wellvision Exam: $0	Wellvision Exam $45
Essential Medical Eye Care	Screening $0 Exam $20	N/A
Frame	$130 frame allowance $150 featured frame brands allowance 20% savings on the amount over your allowance	$70 frame allowance
Lenses	Single Vision: $0 Bifocal: $0 Trifocal: $0	Single Vison $30 Bifocal: $50 Trifocal $65
Lens Enhancements	Standard progressive lenses $0 Premium progressive lenses $95-$105 Custom progressive lenses $150 - $175	N/A
Contacts (instead of eyeglasses)	$130 allowance Contact lens exam (fitting and evaluation) Up to $60	$105 allowance
Frequency	**Exam:** 1 x every 12 months from the last date of service **Frames:** 1 x every 12 months from the last date of service **Lenses**: 1 x every 12 months from the last date of service **Contacts:** 1 x every 12 months from the last date of service	Same as in-network
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.	N/A

ENGAGE

Click to play video



Urgent Care vs ER



Virtual Healthcare

Maximize Your Healthcare

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

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

KNOW WHERE TO GO

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

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

ALTERNATIVE FACILITIES

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

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

How to find an alternative treatment facility

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

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

PREVENTIVE CARE SCREENING BENEFITS

TYPICAL SCREENINGS FOR ADULTS

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

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

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

What is Preventive Care?

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

Visit **cdc.gov/prevention** for recommended guidelines.

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

Not all exams and tests are considered preventive

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

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

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

PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

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

Understanding the formulary can save you money

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

What is a formulary?

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

Get the most from your coverage

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

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

LIFE & DISABILITY

YOUR BENEFICIARY = WHO GETS PAID

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D and disability insurance can fill a number of financial gaps due to a temporary or permanent reduction of income. Consider what your family would need to cover day-to-day living expenses and medical bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (rent or mortgage, children's education, student loans, consumer debt, etc.) after the death of a spouse or partner.

We provide short and long-term disability benefits and a base amount of life and AD&D insurance to help you recover from financial loss.

If you need additional coverage, we offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Benefits section for details.

BASIC LIFE AND AD&D INSURANCE

County of Tuolumne pays for the employee only

Basic Life and AD&D by Mutual of Omaha

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. The cost of coverage is paid in full by the company.

You must be actively working a minimum of 20 hours per week to be eligible for coverage.

Company-provided life insurance coverage over $50,000 is considered a taxable benefit. The value of the benefit over $50,000 will be reported as taxable income on your annual W-2 form.

Life Coverage	For You	For your Spouse	Your Dependent
All Active Full-Time Health Care (Class 2)	$50,000	$500	Six months and older $500; 14 day to less than 6 months $500; less than 14 days $500
All Active Full-Time General, Skilled Trades, Road Operations, Professional (Class 1)	$50,000	$500	Six months and older $500; 14 day to less than 6 months; $500 less than 14 days $500
All Active Full-Time Deputy Sheriffs Association (Class 3)	$50,000	$500	Six months and older $500; 14 day to less than 6 months; $500 less than 14 days $500
All Active Full-Time Management (Class 4)	$100,000	$500	Six months and older $500; 14 day to less than 6 months; $500 less than 14 days $500
All Active Full-Time Attorneys, Executive, Confidential Employees and Elected Officials (Class 5)	$200,000	$500	Six months and older $500; 14 day to less than 6 months; $500 less than 14 days $500
AD&D Coverage	For You		
All Employees	The Principal Sum amount is equal to the amount of your life insurance benefit.		

SHORT-TERM DISABILITY INSURANCE (STD)

(Employer Paid for Executive and Management Employees only).

EXPECT THE UNEXPECTED

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

STD Benefits by Mutual of Omaha

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. County of Tuolumne pays the cost of this coverage.

Eligibility - all eligible active full-time management, other than superior court management, and all active executive and confidential employees.

Guarantee issue is 30 days from hire. No open enrollment.

Disability - Short Term Disability (STD)	
Weekly benefit amount	55% of your before-tax weekly earnings up to a maximum of $1,000
Benefits begin	On the 15th day of your disabling injury or illness.
Maximum payment period	Up to 11 weeks

LONG-TERM DISABILITY INSURANCE (LTD) EMPLOYEE PAID

3 THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

LTD benefits by Mutual of Omaha

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled.

Eligibility - all other eligible employees excluding physicians, superior court management and non-management, deputy sheriffs association, elected officials and retirees with PERS pension

Guarantee issue is 30 days from hire.

Disability - Long Term Disability (LTD)	
Monthly benefit amount	66 2/3% of your before-tax monthly earnings up to a maximum of $6,000
Benefits begin	After 90 days of disability
Maximum payment period	Social Security Normal Retirement Age

VOLUNTARY LIFE

GUARANTEED ISSUE

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

Protecting those you leave behind

Voluntary Life Insurance by Mutual of Omaha 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.

Voluntary Life

Coverage Guidelines	Minimum	Guarantee Issue	Maximum
For you	$10,000	10 times annual salary, up to $250,000	$500,000, in increments of $10,000, but no more than 10 times annual salary
Spouse	$5,000	100% of employee's benefit, up to $30,000	100% of employee's benefit, up to $150,000
Children	$2,000	100% of employee's benefit	100% of employee's benefit, up to $10,000

VOLUNTARY HEALTH-RELATED PLANS

THINGS TO CONSIDER

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

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, as well as 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.

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. Use it to help cover medical costs, transportation, child care, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed.

Mutual of Omaha products can be added during open enrollment without Evidence of Insurability (EOI), which refers to the procedure where individuals submit details about their health.

Added benefit

The Hearing Discount program provides you and your family with discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.

Contact Human Resources for more information.

WELLBEING & BALANCE

“ THE KEY TO KEEPING YOUR BALANCE IS KNOWING WHEN YOU'VE LOST IT. ”

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it’s not always easy.

We offer programs to help you:

- Emotional well-being
- Family and relationships
- Legal and financial
- Healthy lifestyles
- Work and life transitions
- Take time to spend with family and friends, take care of personal business, or just have a little extra “me time”.

Taking care of yourself will help you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Mutual of Omaha's EAP Help for you and eligible dependents.

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Mutual of Omaha can help you handle a wide variety of personal issue such as emotional health and substance abuse; financial coaching; legal consultation; and eldercare resources.

Best of all, contacting the EAP is completely confidential, free and available to any member of your immediate household.

No cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 3 sessions
- Unlimited web access to helpful articles, resources, and self-assessment tools.

CONTACT THE EAP

Website: *mutualofomaha.com/eap*

Phone*:* (800) 316-2796

Note: 3 visits in 6 months

COUNSELING BENEFITS

- Difficulty with relationship
- Emotional distress
- Alcohol or drug problems

CHILDCARE

- Referrals to quality providers

FINANCIAL COACHING

- Telephonic financial consultation
- Financial tools and seminars

LEGAL CONSULTATION

- Online will preparation
- Legal library & online forms

ELDERCARE RESOURCES

- Help with finding appropriate resources to care for an elderly or disabled relative

ONLINE RESOURCES

- Self-help tools to enhance resilience and well-being
- Useful information and links to various services and topics

NEW Anthem Total Health Connections

Helping you and your family feel confident and protected

Employees enrolled in an Anthem medical plan have access to Total Health Connections which provides you and your family with a dedicated Family Advocate — a personal health champion who offers proactive, compassionate, and no-cost support for everyday and emergency health needs. They can help you:

- Find and schedule care with top doctors and facilities in your plan
- Manage preventive care and chronic conditions
- Understand and use your health plan benefits
- Get quick preapprovals for urgent treatments
- Access in-house clinical experts who collaborate with your doctor to create a personal care plan

Focus on your whole health

Whole health also includes your mental health, along with social and community needs. Your dedicated Family Advocate can also connect you with community resources to help with food, childcare, transportation, and other social, financial, or mental health concerns.

A connected health record

You and your Family Advocate, doctors, and pharmacist all have access to the most up-to-date information on your health in a single record. These real-time insights can help improve your care and may lower your healthcare costs over time.

Sydney℠ Health App

Chat with your Family Advocate on our Sydney℠ Health mobile app. The Sydney℠ Health app also gives you a quick way to:

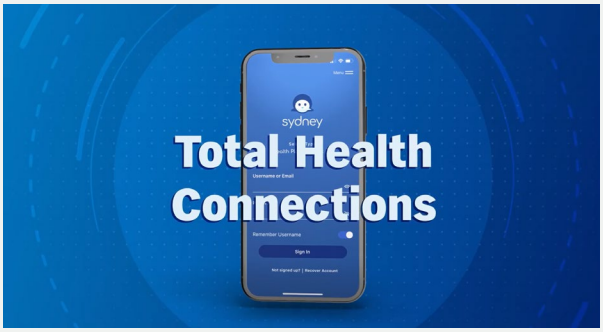
- Use your digital ID card
- Track your health goals and activities
- Check costs and view health plan details
- Access virtual care through video visits or chat

Get Started Today

Download or log in to the Sydney℠ Health mobile app or visit sydneyhealth.com to get started.

Watch the video to learn more about how to get connected with your Family Advocate and access the resources available via the Sydney℠ Health app.

Click to play video



PRISM Value Added Services

Take advantage of these value-added services available to PRISM plan members to help you get and stay healthy.

Benefit Highlights	Availability & How To Get Started
Physical Therapy for Back or Joint Pain **Hinge Health** Get access to free wearable sensors and monitoring devices, unlimited one-on-one coaching and personalized exercise therapy. Available for preventative, acute, and chronic needs at no cost.	*Anthem PPO members* **Call:** (855) 902-2777 **Visit** hingehealth.com/prism/
Hip, Knee & Spine Surgical Benefit & Breast Cancer Treatment Benefit **Carrum Health** Consult top-quality surgeons on hip and knee replacements and certain spine surgeries. Benefit covers all related travel for patient and companion, and medical bills. Oncology benefit also available; guidance for all cancers; treatment for Breast Cancers.	*Anthem PPO members* **Visit** carrumhealth.com
Medicine to treat Diabetes, Obesity & GI **Digbi Health** Access personalized digital care programs that utilize genetic and gut microbiome analysis to address obesity, diabetes, digestive disorders, and related conditions. Services include at-home DNA and gut biome testing, continuous glucose monitoring, personalized nutrition and lifestyle recommendations, access to health coaches, plus medically managed weight loss programs.	*Anthem PPO members* **Call:** (866) 344-2189 **Visit** digbihealth.com/prism
Free Generic Maintenance Medications **Rx 'N Go** As part of your benefits, you have the option to receive up to a 90-day supply of generic maintenance medication by mail at no cost to you ($0 copay, $0 shipping) through a convenient program called, Rx 'n Go.	*Anthem PPO members* **Call:** (888) 697-9646 **Visit** rxngo.com
Discount Medications **GoodRx** Discounts on medications for non-benefit eligible employees. GoodRx allows you to simply and easily search for retail pharmacies that offer the lowest price for specific medications.	*All non-benefit eligible employees* **Members Call:** (888) 799-2553 **Pharmacies Call:** (844) 857-4351 **Visit** gold.goodrx.com

Anthem Resources

Building Healthy Families

Building Healthy Families offers personalized, digital support through the Sydney℠ Health mobile app or on anthem.com/ca. This all-in-one program, at no extra cost to you, can help your family grow strong whether you're trying to conceive, expecting a child, or in the thick of raising young children.

Lark Diabetes Management Program

Available to participants of PPO plans at no cost. Track your progress, check in with your coach, and learn more about prediabetes right in Lark's free mobile app. This program follows guidelines from the Centers for Disease Control and Prevention (CDC) to help you make small changes that can improve your health and decrease your risk over time.

Virtual Primary Care

Through Anthem's LiveHealth Online Virtual Primary Care (LHO VPC), members can choose from board-certified, in-network PCPs, and have that same doctor take care of them overtime for treatments including chronic conditions, preventative care, and acute care, at no extra cost to the member. Copay will still apply.

24/7 Nurse Line

24/7 NurseLine serves as your first line of defense for unexpected health issues. You can call a trained, registered nurse to decide what to do about a fever, give you allergy relief tips, or advise you where to go for care. For help, call the number on the back of your ID card.

Provider Finder
To find a provider in your plan network, please visit www.anthem.com/ca/prism.

Anthem ID Cards

For PPO plans, one ID card will be issued to subscriber and one to spouse/DP. Two cards will be issued in the subscriber's name for subscriber plus child(ren) contracts. ID cards with child dependent names can be requested by calling the member service number on the ID card. PPO enrollees will also receive an Navitus ID card to access pharmacy benefits.

NEW Digbi Health - Diabetes, Obesity & GI Care

Your Digbi Health Journey

The Digbi Health program is a personalized 52-week journey designed to transform your health and wellness. Whether you're managing your weight, Type 2 Diabetes, digestive health, or taking GLP-1s for weight management, Digbi is here to support you with care tailored to your biology. Digbi Health is available at no cost for eligible members covered by Anthem through your employer.

This program includes:

- Gut & Gene Testing Kits
- Glucose Monitoring Device
- Tailored Meals
- Health Coach
- GLP-1s for weight management

Contact Digbi at prism@digbihealth.com or at (866) 344-2189 if you have any questions.

GLP-1 Eligibility

Eligibility requirements for accessing GLP-1s for weight management:

- 18 years or older and enrolled in Anthem (Mandatory).
- BMI 40 or higher without any comorbidity (OR)
- BMI 35 - 39 with at least one related comorbidity (OR)
- Mandatory: If you're on a GLP-1 for weight management, you should have lost 5% weight within 90 days of starting them.
- Digbi to be the sole prescriber for all weight loss medications.

Get Started

1. Check your eligibility and sign up for the program at digbihealth.com/prism.
2. If you are eligible, download the mobile app - onelink.to/digbi.
3. On the app, please confirm shipping address and answer onboarding questions - your kits will be ordered to your address, automatically.
4. Starting January 1, 2026, you will have 90 days to go through Digbi Health's Reauthorization for weight management GLP-1 medication based on the new eligibility criteria.

Digbi Health App

- **Get at-home Test Kits -** Within a week, you'll receive a comprehensive testing kit including a Genetic Test, a Gut Microbiome Test, and an Abbott Libre Continuous Glucose Monitor. Please follow instructions to collect samples and return kits using pre-labeled shipping.
- **Sync your Health Apps -** Connect Apple or Google Health Apps with the Digbi App. Navigate to settings, choose "Health", then connect by tapping "Refresh" under "Apple Health".
- **Say hi to your Coach! -** Tap the 'Coach' button at the bottom to start engaging with your health coach on the app and upload meal pictures for scoring while you await test results.

Kaiser Resources

One Pass Select Affinity by Optum

Through One Pass Select Affinty from Optum members can choose a fitness plan and get unlimited access to all locations available within that plan, plus extensive digital resources. Members can choose the plan that fits their needs, with competitive plans starting at $10 per month. Members that sign up can also access the Optum Additional service include healthy meal delivery and 20% discounts on chiropractors, acupuncturists and massage therapists. Learn more at healthy.kaiserpermanente.org/health-wellness/fitness-offerings.

24/7 care advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider at (866) 454-8855 (NorCal).

Kaiser Away From Home

Kaiser Members are covered for emergency and urgent care anywhere in the world. Visit healthy.kaiserpermanente.org/get-care/traveling to learn about what to do if you need emergency or urgent care during your trip.

Calm App

The Calm app uses meditation and mindfulness to help lower stress, reduce, anxiety, and improve sleep quality. Adult members can get Calm at kp.org/selfcareapps.

Headspace Care App

The Headspace Care app offers immediate 1-on-1 support for coping with many common challenges — from stress and low mood to issues with work and relationships, and more. Headspace Care's highly trained emotional support coaches are ready to help 24/7, and adult Kaiser Permanente members can use Headspace Care for 90 consecutive days at no cost. Get started today at kp.org/selfcareapps.

Finding a Kaiser Provider

To find a Kaiser Permanente provider near you, please visit kp.org or call (800) 464-4000.

My Health Manager

Stay engaged with your health and simplify your busy life by using the Kaiser Website or download the Kaiser Permanente app from the App Store℠ or Google Play®.

Kaiser Resources, Cont.

Online wellness tools

Visit healthy.kaiserpermanente.org/health-wellness for wellness information, health calculators, fitness videos, podcasts, and recipes from world class chefs. Connect to better health with programs to help you lose weight, quit smoking, and more – all at no cost.

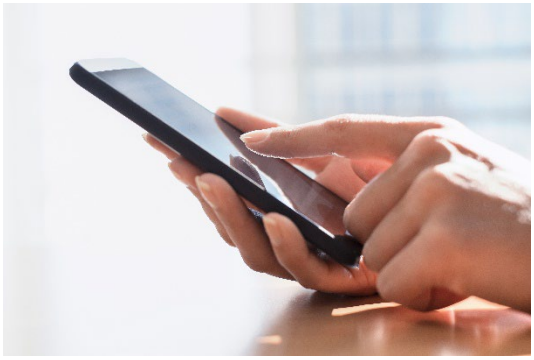
Health classes

Sign up for health classes and support groups at many of our facilities. See what's available near you at healthy.kaiserpermanente.org/health-wellness/classes-programs– some may require a fee.

Personal wellness coaching

Get help reaching your health goals. Work one on one with a wellness coach by phone at no cost. Find out more at healthy.kaiserpermanente.org/health-wellness/wellness-coaching or call (866) 862-4295.

MOBILE RESOURCES



ACCESS YOUR BENEFITS ANYTIME, ANYWHERE

Most of our carriers and vendors have mobile apps available making accessing your benefits information easier than ever.

Just download the apps via the Apple App Store and Google Play and make sure to share with your dependents!

Anthem: Meet Sydney, the mobile app that's all about you, your plan and your health care needs. It connects your questions to answers — and you to the right resources. Using it is like having a personal health assistant in the palm of your hand. Here's why.

- View member ID card
- View claims
- Benefits Information
- Find care and costs
- NurseHelp 24/7
- Wellness
- Find a doctor or urgent care

Kaiser: Manage your health quickly and securely anytime, anywhere it's easy to connect to care, get helpful resources, and more. All in one place. Whenever you need it

- Email your doctor's office with non-urgent questions
- Refill most prescriptions
- Schedule routine appointments
- Pay medical bills
- Find doctors and locations
- Access your digital membership card

IMPORTANT PLAN INFORMATION

For current county contributions please see your individual MOU.

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

- Contact information for our benefit carriers and vendors
- A Benefits Glossary to help you understand important insurance terms.
- A summary of the health plan notices you are entitled to receive annually,.

PLAN CONTACTS

MEDICAL, DENTAL & VISION

Anthem Medical
Group #
PPO Choice – 175075Q500
PPO Care – 175075Q507
PPO Safety – 175075Q514
Anthem.com/ca/prism
Member Services
(800) 967-3015

Anthem NurseLine
(800) 700-9184

Kaiser Medical
Group # 607170
kp.org
Member Services
(800) 464-4000

Delta Dental
Group # 03110
deltadental.com
Member Services
(800) 765-6003

Vision Service Plan (VSP)
Group # 40155188
vsp.com
Member Services
(800) 877-7195

PRESCRIPTION DRUGS

Navitus
Carrier ID#
NVPSM
https://navitus.com/who-we-serve/members/
Member Services
(855) 847-1035

LIFE AND AD&D

Mutual of Omaha
Group # G000AQJX
mutualofomaha.com
Member Services
(800) 228-7104

SHORT-TERM/LONG-TERM DISABILITY

Mutual of Omaha
Group # G000AQJX
mutualofomaha.com
Member Services
(800) 228-7104

ACCIDENT & CRITICAL ILLNESS

Mutual of Omaha
Group # G000AQJX
mutualofomaha.com
Member Services
(800) 228-7104

EMPLOYEE ASSISTANCE PROGRAM EAP

Mutual of Omaha
mutualofomaha.com/eap
Call (800) 316-2796

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

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

GLOSSARY

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more, or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

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

- **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.

SUMMARY PLAN DESCRIPTIONS (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries. If you would like a paper copy, please contact the Plan Administrator.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

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

- Kaiser HMO
- Anthem PPO

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the . 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 County of Tuolumne 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 County of Tuolumne 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. County of Tuolumne has determined that the prescription drug coverage offered by the County of Tuolumne 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 County of Tuolumne 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 County of Tuolumne 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 County of Tuolumne 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 County of Tuolumne 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. 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 County of Tuolumne changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2026
Name of Entity/Sender:	County of Tuolumne
Contact-Position/Office:	Nancy James /Human Resources
Address:	2 South Green Street, Sonora, CA 95370
Phone Number:	(209) 533-6950

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call health plan's Member Services for more information.

Newborns' and Mothers' Health Protection Act

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

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for County of Tuolumne describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Human Resources.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in County of Tuolumne 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 County of Tuolumne health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in County of Tuolumne 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.

Notice of Choice of Providers

County of Tuolumne allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator.

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

You do not need prior authorization from County of Tuolumne 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.

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 March 17, 2026. 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: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ | HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra | Phone: 678-564-1162, press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ | http://www.in.gov/fssa/dfr/ | Family and Social Services Administration Phone: 800-403-0864 | Member Services Phone: 800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: Iowa Medicaid | Health & Human Services | Medicaid Phone: 1-800-338-8366
Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services | Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx | Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov | Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 | TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/ | Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561
CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

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: https://www.hhs.nd.gov/healthcare | Phone: 1-866-614-6005

OKLAHOMA – Medicaid and CHIP

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

OREGON – Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html | Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) | CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

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

SOUTH CAROLINA – Medicaid

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

SOUTH DAKOTA – Medicaid

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

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov | Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2026, 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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.02% in 2025 (9.96% in 2026) of your modified adjusted household income.

Notes