TEHAMA COUNTY

2027 BENEFITS



Keep Your Health in the Game

CONTENTS



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 Plan Information section for more details.

GETTING STARTED	**3**
WHO'S ELIGIBLE FOR BENEFITS?	4
CHANGING YOUR BENEFITS	5
ENROLLING FOR BENEFITS	6
MEDICAL, DENTAL & VISION	
MEDICAL PLAN	8
PRESCRIPTION DRUGS	9
HEALTHCARE FLEXIBLE SPENDING ACCOUNT	15
PAYING FOR DAYCARE?	16
DENTAL PLANS	17
VISION PLANS	19
LIFE BASIC LIFE & AD&D	**21**
VOLUNTARY PLANS	**23**
WELLBEING & BALANCE EMPLOYEE ASSISTANCE PROGRAM (EAP), WELLNESS	**24**
IMPORTANT PLAN INFORMATION BENEFIT COSTS, PLAN CONTACTS, ANNUAL NOTICES	**28**



GETTING STARTED

2027 BENEFITS

January 1st, 2027
through
December 31, 2027

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, Tehama County 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, and more.

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

WHO'S ELIGIBLE FOR BENEFITS?



Employees

You are eligible if you are an employee working 20 or more hours per week.

Eligible dependents

- Legally married spouse.
- A domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit.
- Natural, adopted or stepchildren, or children of a domestic partner up to age 26.
- Children over age 26 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 plan documents for each benefit.

Who is not eligible

Members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Any individual who is covered as an employee of Tehama County cannot also be covered as a dependent.
- Employees who work fewer than 20 hours per week, temporary employees, contract employees, or employees residing outside the United States.

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 30 days. New hires who do not make an election within 30 days of becoming eligible will need to sign a waiver declining coverage.

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

CHANGING YOUR BENEFITS

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.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 30 days of the date the event occurs.
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

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).

Notify Personnel within 30 days if you have a qualifying life event and need to add or drop dependents outside of Open Enrollment.

ENROLLING FOR 2027 BENEFITS

MID-YEAR CHANGES

- You have year-round access to a summary of your benefits through benxcel.net
- Effective 1/1/2027 mid-year changes should be initiated through Benxcel.net. HR may reach out for additional verification prior to approving your election changes.

TROUBLESHOOTING AND HELP

Some of the more common problems you may run into are web-browser-related. If you are having problems with buttons, dropdown menus, or other functions, try it in Google Chrome. Another helpful tip: use the blue "back" buttons on each page to go back to the previous screen instead of clicking "back" in your browser.

If you are still having problems, or have any other questions or concerns, please contact the BCC Customer Service Call Center at **(800) 685-6100.** Representatives are available Monday–Thursday: 5:00 a.m.–5:00 p.m. PT and Friday: 5:00 a.m.–3:00 p.m. PT.

WELCOME TO BENXCEL.NET

These instructions will help you to complete your Open Enrollment benefit elections for the 2027 Plan Year (January 1, 2027 – December 31, 2027) through BenXcel 2.0.

- Open Enrollment Period: **Begins at 12:00 a.m. PT on October 1, 2026, and ends at 11:59 p.m. PT on October 31, 2026.**
- Website: https://benxcel.net
- Company Name: **TEHAMA**

LOG IN INSTRUCTIONS

1. To log into BenXcel, go to: https://benxcel.net
2. Enter your username: your full first name followed by the last four digits of your SSN.

   Enter your initial password: your full first name followed by the last four digits of your SSN
   (ex: john6789)
3. Enter the Company Name: **TEHAMA**
4. Click the Sign In button to enter the system

ENROLLMENT PROCESS

1. Required Employee Usage Agreement, Legal Agreement, and an Open Enrollment Welcome screen will appear.
   Review the messages and click the Continue button to proceed.

2. For security purposes, you will be asked to change your password immediately. A Change Password screen will appear requiring you to
   - Choose two security questions and enter your answers in the Secret Answer fields.
   - Change your password. Your new password must **be a minimum of 8 characters.**
   - Click the Save button when finished.



MEDICAL

OUR PLAN

Anthem Medical EPO

- Consider an EPO (Exclusive Provider Organization) if:
  - You want lower, predictable out-of-pocket costs
  - You like having one doctor to manage your care
  - You are happy with the selection of network providers
  - You don't see any doctors that are out-of-network
- **Plan To Consider**
  - Anthem Medical EPO

Play the Health Lingo Game!



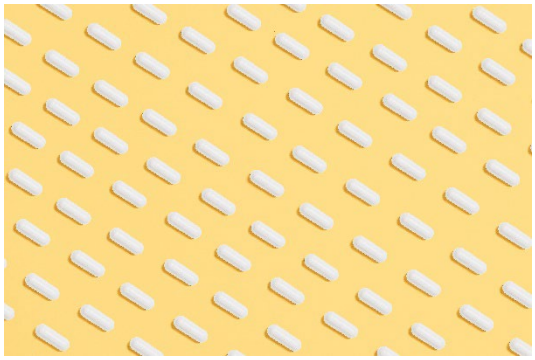
MEDICAL

You always pay the deductible and copayment ($). The coinsurance (%) shows what the plan pays after the deductible.

	Anthem Medical EPO
	In-Network
Calendar Year Deductible[1] Individual Family Embedded	 $500 $1,500 Embedded
Calendar Year Out-of-Pocket Maximum[1,4] Individual Family Embedded	 $3,000 $9,000 Embedded
Office Visit Primary Care Specialist	 $15 Copay $15 Copay
LiveHealth Online Primary Care Specialist	 No Charge $15 Copay (Deductible Does Not Apply)
Preventive Services	No Charge
Chiropractic (up to 24 visits/year)	 90%
Lab and X-ray	90%
Urgent Care	$15 Copay
Emergency Room	$100 Copay 90%[5] (Copay Waived if Admitted)
Inpatient Hospitalization	90%
Outpatient Surgery	90%
PRESCRIPTION DRUGS- NAVITUS	
Out-of-Pocket Maximum	$1,000 per individual
Retail – 30-Day Supply Generics Preferred Brands Non-Preferred Brands Supply Limit	 $10 Copay $20 Copay $30 Copay 30 days
Mail Order – 90-Day Supply Generics Preferred Brands Non-Preferred Brands Supply Limit	 $20 Copay $30 Copay $45 Copay 90 Days

[1]Deductibles and out-of-pocket maximums accumulate on a calendar year deductible January 1st through December 31st.
[2] An embedded family deductible means the plan begins to make payments for a member when they reach their individual deductible.
[3]An embedded family maximum means the plan will cover 100% for an individual member as soon as they reach their individual maximum.
[4]All covered expenses including your medical deductibles and prescription copays accumulate towards the out-of-pocket maximum.
[5]After deductible.

PRESCRIPTION DRUGS FOR ANTHEM MEMBERS– NAVITUS



MANAGE YOUR MEDICATION. ANYTIME. ANYWHERE.

Online access to savings and convenience with navitus.com and the Navitus mobile app.

Once members have logged on to the Member Portal, the formulary list is located under My Plan> Forms and Documents>Formulary

Understanding Your Pharmacy Benefits

Members who take stabilized doses of covered long-term maintenance medications — like those used to treat an ongoing condition such as high blood pressure or high cholesterol — can save money by ordering them through Navitus' mail service partner, Costco Pharmacy, instead of using a retail pharmacy.

With the Costco Home Delivery Pharmacy

- You get up to a 90-day supply delivered directly to you — with free standard shipping.
- You can easily order refills online, over the phone or by mail.
- Multiple safety and advanced quality checks are in place to make sure you get the right medication.
- You do not need to be a Costco member to utilize the Home Delivery benefit

Please contact Costco Home Delivery Pharmacy at pharmacy.costco.com. You may also call 1-800-607-6861 for home delivery forms and instructions. Please note that some pharmacies may not be in your plan. Log into the member home page at navitus.com to find pharmacies that are in your plan, or call (866) 333-2757.

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.

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:

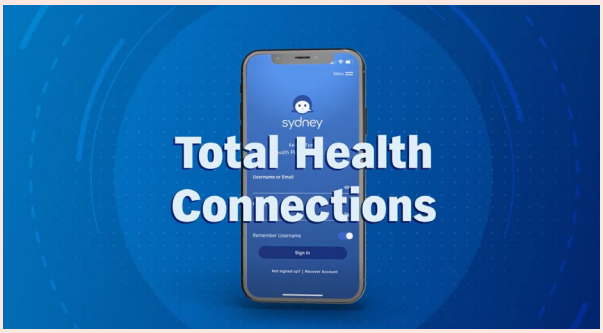
- Use your digital ID card
- Track your health goals and activities
- Check costs and view health plan details
- Access virtual care through video visits or chat

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



NEW! Carrum Health – Substance Use Treatment

New benefit options, same expert care.

Your Carrum Health benefit just got better. Now you can get even more care—still at little to no cost to you.*

Scan me for more information!

Your additional benefits include:

- Detox services
- Residential/inpatient rehab
- Intensive outpatient treatment
- Outpatient treatment

If you or your covered family member (age 18+) needs support for alcohol or substance use, we'll quickly connect you with one of the country's top recovery centers based on your personal needs. We'll be here to guide you every step of the way. Often, you'll pay little, if anything, for the excellent care you receive.*

- Recovery coaching
- Virtual care
- Medication-assisted treatment

and more!

- Substance use treatment: Personalized recovery programs for alcohol and opioid addiction from leading treatment centers.

Covered services include:

To see all your benefit options, visit carrum.me/prism or call 888-855-7806

*With the exception of second opinions, due to IRS rules, members on a high-deductible plan must pay their deductible, but coinsurance and copays are waived. The second opinion service is free, and most will be done virtually. Per IRS rules, a portion of any covered travel expenses will be reported as taxable income.
BCCR - 193-20260416

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.	**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 cancer.	**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, and access to health coaches	**Call:** (866) 344-2189 **Visit** digbihealth.com/prism
Free Generic Maintenance Medications **Rx'NGo** 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.	**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

NEW! Reintroducing...
Digbi Health - Diabetes, Obesity & GI Care



Questions?
Review the Digbi Health FAQ to learn more about the program offerings.

Your Digbi Health Journey

The Digbi Health program is a personalized 52-week journey designed to transform your health and wellness. Whether you have Type 2 Diabetes or digestive health, 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

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

GLP-1 Eligibility

Coverage for Non-Diabetic Weight Loss GLP-1 Medications Will End

Beginning January 1, 2027:

- Coverage for non-diabetic GLP-1 medications will no longer be available under the PRISMHealth program. Only those with a Type 2 Diabetes diagnosis will be covered for GLP-1s under the Health Plan.
- Existing prior authorizations will not continue into 2027.
- Grandfathering provisions will not apply.
- Weight loss GLP-1 medications will not be included on the PPO formulary. This applies to PPO, EPO, and HDHP plans.
- For HMO and Kaiser plans, these non-diabetic GLP-1 medications no longer require Digbi as the sole prescriber on 1/1/2027 and are covered only with a BMI over 40 or between 35 and 40 with a comorbidity.

Through December 31, 2026:

- Digbi Health remains the exclusive prescriber for weight loss/non-diabetic GLP-1 medications under the PRISMHealth program.
- Members currently using weight loss GLP-1 medications may be required to complete a 6-month reauthorization process.
- Digbi Health is working directly with affected members throughout the reauthorization process.

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 at onelink.to/digbi.
3. On the app, please confirm address and answer onboarding questions - your kits will be ordered to your address, automatically.

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.

RESOURCES FOR ANTHEM MEMBERS



FINDING AN ANTHEM PROVIDER

To find a provider in the Anthem network, please visit anthem.com/ca/prism/home.

ANTHEM ID CARDS

For PPO plans, one ID card will be issued to subscriber and one to spouse/domestic partner. 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. ID cards will be issued to each member enrolled. PPO/EPO enrollees will also receive a Navitus ID card to access pharmacy benefits.

Sydney Mobile App

Use Sydney™ Health to keep track of your health and benefits—all in one place. Access your plan details, Member Services, virtual care, and wellness resources. You can also set up an account at anthem.com/ca/register to access most of the same features from your computer.

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 Prevention Program

Available to participants 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. Visit lark.com/anthemBC.

ConditionCare

ConditionCare is a disease management program available to members at no cost. The program provides tools, resources and support with Asthma (pediatric or adult), Chronic obstructive pulmonary disease (COPD), Coronary artery disease, Diabetes, types 1 and 2 (pediatric or adult) or Heart failure. For more details and/or to join, call the member services on your ID Card.

LiveHealth Online

Visit with a board-certified doctor using your smartphone, tablet or computer with a webcam. Doctors are available 24/7 to assess your condition and, if it's needed, they can send a prescription to your local pharmacy. Register online at livehealthonline.com and download the mobile app.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video



ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA.

Find out more

- FSA website
- Eligible Expenses – now include more over-the-counter items!
- Ineligible Expenses

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year. This program is administered through BCC.

Here's how the FSA plan works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to $3,400. The 2027 annual limit has not yet been announced by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.
- Expenses must be incurred between 01/01/2027 and 12/13/2027 and claims must be submitted for reimbursement no later than 03/30/28. If you don't spend all the money in your account, any remaining balance will be forfeited.
- Elections cannot be changed during the plan year, unless you experience a qualifying event.
- You must re-enroll in this program each year.

FSA TAX SAVINGS EXAMPLE

$60,000 Annual Pay, with $1,500 FSA Contribution

$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings

$120,000 Annual Pay, with $2,750 FSA Contribution

$660 24% Federal income tax	**$210** 7.65% FICA tax	**$870** Annual FSA tax savings

Your tax savings may vary depending on tax filing status and other variables

PAYING FOR DAYCARE? MAKE IT TAX-FREE!



EVERY OPPORTUNITY TO SAVE

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up to $7,500 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by BCC.

Here's how the Dependent Care FSA works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $7,500 per household per year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to $3,750 each year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Estimate carefully! You can’t change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.



DENTAL

OUR PLAN

Delta Dental DPPO Plan PRISM

DID YOU KNOW?

Keeping your teeth and gums healthy isn't the only reason you should practice preventive dental care. With good dental hygiene, you can greatly reduce your risk of getting cavities, gingivitis, periodontitis, and other dental problems.

You can also reduce your risk of secondary problems caused by poor oral health such as diabetes, heart disease, osteoporosis, respiratory disease and even cancer.

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

DENTAL

You always pay the deductible and copayment ($). The coinsurance (%) shows what the plan pays after the deductible.

	Delta Dental DPPO Plan PRISM	
	In-Network	**Out-of-Network**
Annual Deductible	$25 Per Individual $75 Per Family	$25 $75
Annual Plan Maximum	$1,700 Per Individual	$1,500 Per Individual
Diagnostic & Preventive	100%	100%
Basic Services Fillings Root Canals Periodontics	 80% 80% 80%	 80% 80% 80%
Major Services	80%	80%
Orthodontia Adults Children	Not Covered	Not Covered

What you need to know about this plan



Features:	See any provider, but you'll pay more out of network
Am I restricted to in-network providers?	No
Do I have to select a primary dentist?	No
Can I use my HSA or FSA?	If you participate in a healthcare FSA you can use your account to pay for dental expenses.



VISION

OUR PLAN

VSP Vision Plan PRISM

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 and PRK, rebates on contact lenses, and money off on hearing aids and other related services. Visit the plan's website to check out these extra savings.

VISION

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

	VSP Vision Plan PRISM	
	In-Network	**Out-of-Network**
Exams Benefit Materials Frequency	 $10 Copay $20 Copay Once every 12 months	 Up To $45 N/A In-network limitations apply
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	 Plan Pays 100% Plan Pays 100% Plan Pays 100% Once every 12 months	 Up to $30 Up to $50 Up to $65 In-network limitations apply
Frames Benefit Frequency	 $150 Allowance (20% Discount over allowance) Once every 24 months	 Up to $70 In-network limitations apply
Contacts (Elective) Conventional Frequency	 $130 Allowance (copay waived; instead of glasses) Once every 12 months	 Up to $105 (in-network limitations apply) In-network limitations apply

What you need to know about this plan



Features: See any provider, but you'll pay more out of network

What other services are covered? The plan can also help you save money on LASIK procedures, sunglasses, computer glasses, and even hearing aids.

Eyeglasses are expensive. Will I still be able to afford them, even with insurance? Look for moderately priced frames and remember that your benefit is higher in-network. If you participate in a healthcare FSA you can use your account to pay for vision care and eyewear with tax-free dollars.

Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change.
Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.
Coverage with a retail chain may be different or not apply.



LIFE

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 and AD&D 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.

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.

COMPANY-PROVIDED LIFE AND AD&D INSURANCE



Basic Life and AD&D

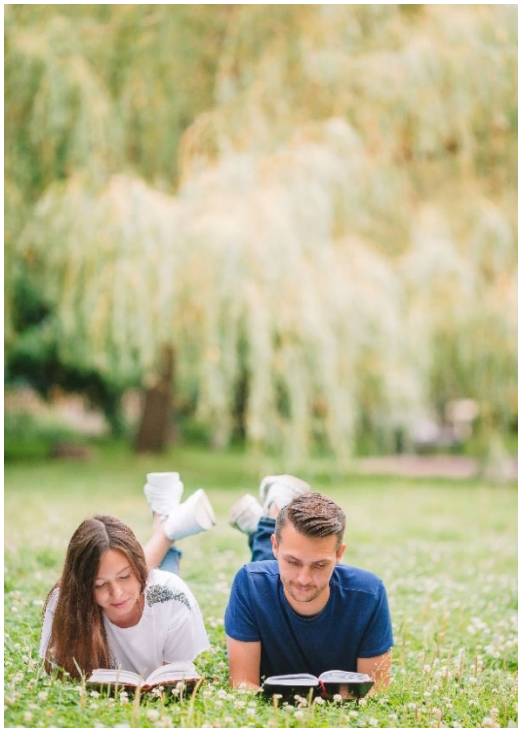
Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. Coverage is provided by VOYA Financial and premiums are paid in full by Tehama County.

VOYA Financial Basic Life and AD&D

Class 1: Active Management, Court Management, LEMA, DSA, Misc. Bargaining Unit Employees and Peace Officers' Bargaining Unit Employees	$30,000
Class 2: All Other Active Employees	$20,000
Class 3: All Other Retirees	$1,000
Class 4: Management and LEMA Retirees	$5,000
Class 5: Active Court Misc. Employees	$20,000

The benefit amounts above will be reduced if you are age 65 or older. Refer to the plan document for details.

VOLUNTARY LIFE AND AD&D INSURANCE



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 allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by VOYA Financial and available for your spouse and/or child(ren).

VOYA Financial Voluntary Life

Employee	Increments of $10,000 (minimum $20,000) up to Lesser of 5 x covered annual earnings or $500,000 Guaranteed Issue: $150,000
Spouse	Increments of $5,000 (minimum $10,000) up to $250,000 and not to exceed 50% of employee amount Guaranteed Issue: $50,000
Child(ren)	$10,000 Guaranteed Issue: $10,000

Note: Benefit amount reduces to 65% at age 65.

Evidence of Insurability (EOI)

If you select a coverage amount above a certain limit you will need to submit an Evidence of Insurability form with additional information about your health in order for the insurance company to approve this higher amount of coverage.



WELLBEING & BALANCE

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

The challenges of daily life can be hard to balance. Whether it’s work, school or family obligations, it’s no wonder that many of us sometimes have trouble managing the ups and downs of our day-to-day lives.

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 an Employee Assistance Program (EAP) to help you manage stress, chemical dependency, mental health and family issues.

Taking care of yourself will help you be more effective in all areas of your life.

EMPLOYEE ASSISTANCE PROGRAM (EAP)



CONTACT THE EAP

Phone
(800) 932-0034
Website
www.myassistanceprogram.com

ALLONE HEALTH

Scan the QR code to Log In to the Member Portal →

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through AllOne Health can help you handle a wide variety of personal issues such as emotional health and substance abuse; parenting and childcare needs; 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; the program allows you and your family/household members up to 3 per incident per year.
- Unlimited web access to helpful articles, resources, and self-assessment tools

COUNSELING BENEFITS

- Difficulty with relationship
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

PARENTING & CHILDCARE

- Referrals to quality providers
- Family day care homes
- Infant centers and preschools
- Before/after school care
- 24-hour care

FINANCIAL COACHING

- Money management
- Debt management
- Identity theft resolution
- Tax issues

LEGAL CONSULTATION

- Referral to a local attorney
- Family issues (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

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

EMPLOYEE ASSISTANCE PROGRAM (EAP)



CONTACT THE EAP

Phone
1(833) 303-3750

Website
One.telushealth.com

Username: PRISM
Password: PRISM

Scan here for the App Store

Scan here for Google Play

Help for you and your household members

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through TELUS can help you handle a wide variety of personal issues such as emotional health and substance abuse; parenting and childcare needs; 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
- Unlimited web access to helpful articles, resources, and self-assessment tools

COUNSELING BENEFITS

- Difficulty with relationship
- Emotional distress
- Job stress
- Communication/ conflict issues
- Alcohol or drug problems
- Loss and death

VOYA VALUE-ADDED SERVICES



GET STARTED TODAY

To access these value-added services, visit guidanceresources.com or download our mobile app "GuidanceNow" from your favorite app store.

Estate Planning

EstateGuidance® makes it easy with online tools that walk you through the process in minutes. Just access the site using the directions provided and supply the information. Your will can be completed online and downloaded to your computer or printed and shipped to you.

Financial Resources

Just call your Guidance Resources toll-free number. You'll be connected to a Guidance Consultant who will talk with you about your specific situation and schedule a phone appointment for you with one of our financial experts.

Funeral Planning

Funeral planning and concierge services are provided by Everest Funeral Package, LLC, which offers both pre-planning and at-need services at or near the time of need. At-need services include price negotiation assistance and communicating the family's wishes to the funeral home. Contact an Everest Service Advisor at (800) 913-8318.

Travel Assistance

A comprehensive worldwide travel assistance program that includes pre-trip planning and emergency assistance to covered persons while traveling 100 miles or more from home. Call (800) 859-2821 or (202) 296-8355 for more info!

Legal Guidance

You'll be connected to a Guidance Consultant who will talk with you about your situation and schedule a phone appointment for you with one of our staff attorneys. If you need more immediate help, you can be connected to an attorney directly.



IMPORTANT PLAN INFORMATION

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

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

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify Tehama County if your domestic partner is your tax dependent.

COST OF COVERAGE-MONTHLY PREMIUMS

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

All Full Time Tehama County Employees

	EPO	PPO
Medical	$2,648	$3,279
Dental	$88.67	$88.67
Vision	$12.49	$12.49
Life ($30,000)	$5.58	$5.58
TPA Fee	$0.50	$0.50
Total Premium	**$2,755.24**	**$3,386.24**
Less County Contribution	$2,456.59	$2,456.59
Employee Portion of full package	$298.65	$929.65
Employee Portion of life insurance purchased separately ($30,000)	$1.12*	$1.12*

*If you are a part-time employee you will pay a greater portion of the premium. Contact the Auditor's Office for the exact premium amount.
Please note that certain Court employees may have a different life insurance amount. Please contact your Personnel Office for clarification.

COST OF COVERAGE-CONTINUED-MONTHLY PREMIUMS

MEDICAL	EPO	PPO
Retiree only under 65	$2,648.00	$3,279.00
Retiree + Spouse both under age 65	$2,648.00	$3,279.00
Retiree + Spouse both under age 65 plus family	$2,648.00	$3,279.00
Retiree only, age 65 or older	$1,207.00	$1,587.00
Retiree + Spouse, both age 65 or older	$2,413.00	$3,172.00
Retiree (both 65+) and Family	$3,378.00	$4,245.00
Retiree + Spouse, one over & one under age 65 (one w/Medicare, one w/o Medicare)	$2,516.00	$3,378.00
Retiree + Spouse, one over & one under age 65 (one w/Medicare, two w/o Medicare)	$3,840.00	$5,018.00
Retiree + Spouse, one over & one under age 65 (two w/Medicare, one w/o Medicare)	$3,481.00	$4,451.00
Dental	$88.67	$88.67
Vision	$12.49	$12.49
Life Policy ($1,000)	$0.20	$0.20
Life Policy ($5,000)	$1.00	$1.00

Retiree over 65 + Family contact BCC.

COBRA RATE-MONTHLY PREMIUMS

	EPO	PPO
Medical	$2,700.96	$3,344.58
Dental	$90.44	$90.44
Vision	$12.74	$12.74
Total Premium	**$2,804.14**	**$3,447.76**

*Premiums for COBRA include a 2% administration fee.

PLAN CONTACTS

If you need to reach our plan providers, here is their contact information:

Plan Type	Provider	Phone Number	Website
Medical	Anthem	(800) 967-3015	anthem.com/ca/prism
Prescription Drugs	Navitus	(866) 333-2757	www.navitus.com
Dental	Delta Dental	(800) 765-6003	deltadentalins.com
Vision	VSP	(800) 877-7195	vsp.com
Life and AD&D	VOYA	(800) 955-7736	voya.com
Employee Assistance Program	ACI Specialty Benefits	(800) 932-0034	acispecialtybenefits.com
FSA	BCC Administrative	(800) 685-6100	www.benxcel.com

IMPORTANT PLAN INFORMATION

WHAT YOU NEED TO KNOW ABOUT THE "NO SURPRISES" RULES

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

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 underage 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.

Medicare Part D Notice

Important Notice from Tehama County 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 Tehama County 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. Tehama County has determined that the prescription drug coverage offered by Tehama County 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 Tehama County 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 Tehama County 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 Tehama County 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 Tehama County 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 Personnel Office 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 Tehama County 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:	10/1/2026
Name of Entity/Sender:	Tehama County
Contact-Position/Office:	Personnel Office
Address:	727 Oak Street, Red Bluff, CA 96080
Phone Number:	(530) 527-4183

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. Therefore, the following deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call your plan administrator (530) 527-4183.

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 at (530) 527-4183.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Tehama County's 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 Tehama County's health plan without waiting for the next open enrollment period if you:

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

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

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

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Tehama County describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting (530) 527-4183.

Michelle's Law

The Tehama County plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, notify Personnel Office in writing as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

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

- If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov/.
- If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.
- If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.
- If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.
- If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility.

Alabama – Medicaid

Website: myalhipp.com
Phone: (855) 692-5447

Alaska – Medicaid

The AK Health Insurance Premium Payment Program
Website: myakhipp.com
Phone: (866) 251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid eligibility:
health.alaska.gov/dpa/Pages/default.aspx

Arkansas – Medicaid

Website: myarhipp.com
Phone: (855) MyARHIPP (692-7447)

California – Medicaid

Health Insurance Premium Payment (HIPP) Program
Website: dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance
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: healthfirstcolorado.com
Health First Colorado Member Contact Center: (800) 221-3943 (TTY: 711)
CHP+: hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: (800) 359-1991 (TTY: 711)
Health Insurance Buy-In Program (HIBI): mycohibi.com
HIBI Customer Service: (855) 692-6442

Florida – Medicaid

Website:
flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp
Phone: (877) 357-3268

Georgia – Medicaid

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

Illinois – Medicaid

Illinois Medicaid Premium Assistance Information
Medicaid application website: abe.illinois.gov
HIPP Hotline Number: (217) 524-8268
HIPP Email: mhfs.boc.hipp@illinois.gov

Indiana – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: in.gov/medicaid
Website: 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: hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid phone: (800) 338-8366
Hawki website: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: (800) 257-8563
HIPP website: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
HIPP Phone: (888) 346-9562

Kansas – Medicaid

Website: kancare.ks.gov
Phone: (800) 792-4884
HIPP Phone: (800) 967-4660

Kentucky – Medicaid

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

Louisiana – Medicaid

Louisiana Medicaid website: ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: (888) 342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP)
Website: ldh.la.gov/lahipp
LaHIPP phone: (877) 697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: (888) 716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084

Maine – Medicaid

Enrollment website: mymaineconnection.gov/benefits
Phone: (800) 442-6003 (TTY: 711)
Private Health Insurance Premium webpage:
maine.gov/dhhs/ofi/applications-forms
Phone: (800) 977-6740 (TTY: 711)

Massachusetts – Medicaid and CHIP

Website: mass.gov/masshealth/pa
Phone: (800) 862-4840 (TTY: 711)
Email: masspremassistance@accenture.com

Minnesota – Medicaid

Website: mn.gov/dhs/health-care-coverage/
Phone: (800) 657-3672

Missouri – Medicaid

Website: mydss.mo.gov/mhd/healthcare
Phone: (573) 751-2005

Montana – Medicaid

Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: (800) 694-3084
Email: HHSHIPPProgram@mt.gov

Nebraska – Medicaid

Website: accessnebraska.ne.gov
Phone: (855) 632-7633
Lincoln: (402) 473-7000
Omaha: (402) 595-1178

Nevada – Medicaid

Medicaid website: dhcfp.nv.gov
Medicaid phone: (800) 992-0900

New Hampshire – Medicaid

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

New Jersey – Medicaid and CHIP

Website: nj.gov/humanservices/dmahs/individuals-families/familycare
Phone: (800) 356-1561
CHIP Premium Assistance Phone: (609) 631-2392
CHIP phone: (800) 701-0710 (TTY: 711)

New York – Medicaid
Website: health.ny.gov/health_care/medicaid
Phone: (800) 541-2831

North Carolina – Medicaid
Website: medicaid.ncdhhs.gov
Phone: (919) 855-4100

North Dakota – Medicaid
Website: hhs.nd.gov/healthcare
Phone: (866) 614-6005

Oklahoma – Medicaid and CHIP
Website: insureoklahoma.org
Phone: (888) 365-3742

Oregon – Medicaid
Website: healthcare.oregon.gov
Phone: (800) 699-9075

Pennsylvania – Medicaid and CHIP
Website: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: (800) 692-7462
CHIP website: dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP phone: (800) 986-KIDS (5437)

Rhode Island – Medicaid and CHIP
Website: eohhs.ri.gov
Phone: (855) 697-4347 or (401) 462-0311 (Direct RIte Share Line)

South Carolina – Medicaid
Website: scdhhs.gov
Phone: (888) 549-0820

South Dakota – Medicaid
Website: dss.sd.gov
Phone: (888) 828-0059

Texas – Medicaid
Website: hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: (800) 440-0493

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

Vermont – Medicaid
Website: dvha.vermont.gov/members/medicaid/hipp-program
Phone: (800) 250-8427

Virginia – Medicaid and CHIP
Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
Website: coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP phone: (800) 432-5924

Washington – Medicaid
Website: hca.wa.gov
Phone: (800) 562-3022

West Virginia – Medicaid and CHIP
Website: bms.wv.gov
Website: mywvhipp.com
Medicaid phone: (304) 558-1700
CHIP toll-free phone: (855) MyWVHIPP (699-8447)

Wisconsin – Medicaid and CHIP
Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: (800) 362-3002

Wyoming – Medicaid
Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: (800) 251-1269

To see if any other states have added a premium assistance program since July 31, 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 10.22% in 2027 of your modified adjusted household income.