2026
SUTTER COUNTY EMPLOYEE BENEFITS

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

2026 BENEFITS

January 1, 2026
through
December 31, 2026

At Sutter County, we believe that you, our employees, are our most important asset. Helping you and your families achieve and maintain good health—physical, emotional and financial—is the reason Sutter County offers you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how to best use them. Please review it carefully and make sure to ask about any important issues that are not addressed here. A list of plan contacts is provided at the back of this summary.

While we've made every effort to make sure that this guide is comprehensive, it cannot 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. The benefit summaries in this booklet are for informational purposes only. It does not amend, extend, or alter the current policy in any way. In the event information in these summaries differs from the Plan Documents, the Plan Documents will prevail.

WHO CAN YOU COVER?

WHO IS NOT ELIGIBLE?

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

- Parents, grandparents, and siblings.
- Employees who work less than 20 hours per week, temporary employees, contract employees, or employees residing outside the United States.

WHO IS ELIGIBLE?

In general, Full-Time employees are eligible for benefits outlined in this review.

In order to comply with the Affordable Care Act (ACA), Sutter County determines your eligibility for medical coverage based on the number of hours you work each month. You can enroll the following family members in our medical, dental and vision plans.

- Your spouse (the person who you are legally married to under state law, including a same-sex spouse.)
- Your registered domestic partner is eligible for coverage if you have completed a Registered Domestic Partner Affidavit. Please review the affidavit carefully because it includes important information about the guidelines for adding, ending or changing your registered domestic partner. Any premiums for your registered domestic partner paid for by Sutter County are taxable income and will be included on your W-2. Any premiums you pay for your registered domestic partner will be deducted on an after-tax basis. Contact your tax advisor about your registered domestic partner's tax dependent status and advise Sutter County if your registered domestic partner is a tax dependent.
- Your children (including your natural, adopted, legal guardianship, and registered domestic partner's children):
  - Under the age of 26 are eligible to enroll in medical, dental and vision coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.

WHEN CAN I ENROLL?

Coverage for new employees begins on the 1st of the month following 30 days.
Open enrollment for current full-time employees is generally held in October each year.

Make sure to notify Human Resources right away if you do have a qualifying life event and need to make a change (add or drop) to your coverage election. Life events include (but are not limited to):

· Birth or adoption of a baby or child (31 Days)
· Loss of other healthcare coverage (31 Days)
· Marriage/Domestic Partnership (31 Days)
· Divorce/Termination of Domestic Partnership (31 days)

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).

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

Dependent Verification

Making changes to dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You will be required to provide proof of one or more of the following within XX days of their eligibility:

- Marriage Certification or License
- Domestic Partners Affidavit
- Birth Certificate
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)

If you do not supply the proper documentation to make changes to dependents within the 30-day period, you will not be able to add the dependent(s) until the next open enrollment period.

MAKING THE MOST OF YOUR BENEFITS PROGRAM

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STAY WELL!

Harder than it sounds, of course, but many health problems are avoidable. Take action—from eating well, to getting enough exercise and sleep. Taking care of yourself takes care of a lot of potential problems.

ASK QUESTIONS AND STAY INFORMED

Know and understand your options before you decide on a course of treatment. Informed patients get better care. Ask for a second opinion if you're at all concerned.

GET A PRIMARY CARE PROVIDER

Having a relationship with a PCP gives you a trusted person who knows your unique situation when you're having a health issue. Visit your PCP or clinic for non-emergency healthcare.

USING THE EMERGENCY ROOM

Did you know most ER visits are unnecessary? Use them only in a true emergency—like any situation where life, limb, and vision are threatened. Otherwise, call your doctor, your nurse line, or go to an Urgent Care Clinic. You'll save a lot of money and time.

GOING TO THE DOCTOR?

To get the most out of your doctor visit, being organized and having a plan helps. Bring the following with you:

- Your plan ID card
- A list of your current medications
- A list of what you want to talk about with your doctor

AN APPLE A DAY

Eating moderately and well really does help keep the doctor away. Stay away from fat-heavy, processed foods and instead focus on whole grains, vegetables, and lean meats to be the healthiest you can be.

TAKE YOUR MEDICATION!

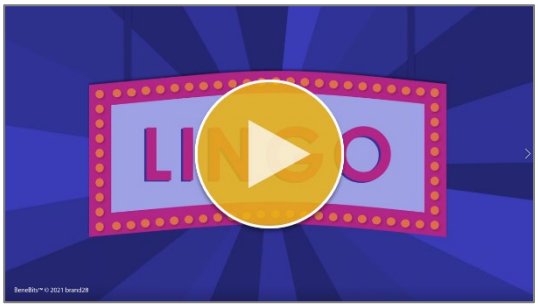
Always follow your doctor's and pharmacist's instructions when taking medications. You can worsen your condition(s) by not taking your medication or by skipping doses. If your medication is making you feel worse, contact your doctor. If you need a medication, you could save money by asking your doctor if there are generics or generic alternatives for your specific medication.

MEDICAL

WORDS TO KNOW

Can you beat the Health Lingo game? Learn the words that will help you understand how your plan works.

Click to play video



- **ANTHEM 500 PLAN TERMINATION: Employees on this plan must enroll or they will automatically be enrolled in the Anthem HDHP Plan**
- **DEDUCTIBLE:** The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.
- **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 eligible expenses for the rest of the plan year.
- **COINSURANCE:** After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.
- **COPAY:** A set fee you pay instead of coinsurance for some healthcare services, for example, a doctor's office visit. You pay the copay at the time you receive care.
- **IN-NETWORK / OUT-OF-NETWORK:** In-network services will always be the lowest cost option. Out-of-network services will cost more, or may not be covered. Check your plan's website to find doctors, hospitals, labs, and pharmacies that belong to the network.

KAISER HMO

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

	Kaiser HMO	
	In-Network High Plan	In-Network Low Plan
Calendar Year Deductible[1] Individual Family	$0 per individual $0 per family	$0 per individual $0 per family
Calendar Year Out-of-Pocket Maximum[1] Individual Family	$1,500 per individual $3,000 per family	$1,500 per individual $3,000 per family
Office Visit Primary Care Specialist	$10 copay $10 copay	$20 copay $20 copay
Online Visit		
Preventive Services	Plan pays 100% (see contract for limitations)	Plan pays 100% (see contract for limitations)
Chiropractic	$10 copay, up to 30 visits per year	$10 copay, up to 30 visits per year
Lab and X-ray	Plan pays 100%	Plan pays 100%
Urgent Care	$10 copay	$20 copay
Emergency Room	$50 copay (copay waived if admitted)	$50 copay (copay waived if admitted)
Inpatient Hospitalization	Plan pays 100%	$500 admission copay
Outpatient Surgery	$10 copay (per procedure)	$20 copay (per procedure)
PRESCRIPTION DRUGS		
Calendar Year Deductible	None	None
Out-of-Pocket Maximum	None	None
Retail-Up To 100 Day Supply Generic Preferred Brand	$5 copay $15 copay	$10 copay $35 copay
Mail Order- Up To 100 Day Supply Generic Preferred Brand	$5 copay $15 copay	$10 copay $35 copay

ANTHEM BLUE CROSS PPO 1000

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

	Anthem Medical PPO 1000	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	$1,000 per Individual $2,000 per Family	
Calendar Year Out-of-Pocket Maximum Individual Family	$4,000 per Individual $8,000 per Family	$10,000 per Individual $20,000 per Family
Office Visit Primary Care Specialist	$45 copay deductible waived $45 copay deductible waived	Plan pays 50% after deductible Plan pays 50% after deductible
Preventive Services	Plan pays 100%	Plan pays 50% after deductible
Chiropractic (up to 12 visits/year)	$25 copay per visit (deductible waived)	Plan pays 50% after deductible
Lab and X-ray	Diagnostic: Plan pays 100% after deductible Complex: Plan pays 80% after deductible	Plan pays 50% after deductible
Urgent Care	$45 copay (deductible waived)	Plan pays 50% after deductible
Emergency Room	$100 deductible then plan pays 80%)copay waived if admitted)	$100 deductible then plan pays 80%)copay waived if admitted)
Inpatient Hospitalization	Plan pays 80% after deductible, maximum of $1,000 cost share per year	Plan pays 50% after deductible (max $600 per day, $250 deductible if utilization review is not obtained for non-emergency admission)
Outpatient Surgery	$250 per surgery then plan pays 80% after deductible	Plan pays 50% after deductible (benefit limited to $350 per visit)
PRESCRIPTION DRUGS – Express Scripts		
Calendar Year Deductible	None	None
Out-of-Pocket Maximum	$2,000 per Individual $4,000 per Family	Out of network claims do not apply to out of pocket limit
Retail- 30 Day Supply Generic Preferred Brand Non-Preferred Brand	$10 copay $20 copay $35 copay	$10 copay $20 copay $35 copay
Mail Order- 90 Day Supply Generic Preferred Brand Non-Preferred Brand	$20 copay $40 copay $60 copay	Not Available

ANTHEM BLUE CROSS PPO 1500

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

	Anthem Medical PPO 1500	
	In-Network	**Out-of-Network**
Calendar Year Deductible Individual Family	$1,500 per Individual $3,000 per Family	
Calendar Year Out-of-Pocket Maximum Individual Family	$5,000 per Individual $10,000 per Family	$10,000 per Individual $20,000 per Family
Office Visit Primary Care Specialist	$45 copay deductible waived $45 copay deductible waived	Plan pays 50% after deductible Plan pays 50% after deductible
Preventive Services	Plan pays 100%	Not covered
Chiropractic (up to 12 visits/year)	$25 copay per visit (deductible waived)	Plan pays 50% after deductible
Lab and X-ray	Diagnostic: Plan pays 100% after deductible Complex: Plan pays 80% after deductible	Plan pays 50% after deductible
Urgent Care	$45 copay (deductible waived)	Plan pays 50% after deductible
Emergency Room	$100 deductible then plan pays 80%)copay waived if admitted)	$100 deductible then plan pays 80%)copay waived if admitted)
Inpatient Hospitalization	Plan pays 80% after deductible, maximum of $1,000 cost share per year	Plan pays 50% after deductible (benefit limited to $1,000 a day)
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 50% after deductible (benefit limited to $350 per visit)
PRESCRIPTION DRUGS – Express Scripts		
Calendar Year Deductible	None	None
Out-of-Pocket Maximum	$2,000 per Individual $4,000 per Family	Out of network claims do not apply to out of pocket limit
Retail- 30 Day Supply Generic Preferred Brand Non-Preferred Brand	$10 copay $20 copay $35 copay	$10 copay $20 copay $35 copay
Mail Order- 90 Day Supply Generic Preferred Brand Non-Preferred Brand	$20 copay $40 copay $60 copay	Not Available

ANTHEM BLUE CROSS PPO HDHP 3400

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

	Blue Cross PPO HDHP 3400	
	In-Network	Out-of-Network
Annual Deductible[1] Individual Family	$3,400 per individual $6,800 per family	$3,400 per individual $6,800 per family
Annual Out-of-Pocket Maximum[1] Individual Family	$3,400 per individual $6,800 per family	$5,000 per individual $10.000 per family
Lifetime Max	Unlimited	Unlimited
Office Visit Primary Care Specialist	Plan pays 100% after deductible Plan pays 100% after deductible	Plan pays 50% after deductible Plan pays 50% after deductible
Online Visit		
Preventive Services	Plan pays 100% deductible waived	Plan pays 50% after deductible
Chiropractic (up to 24 visits per year combined with Physical Therapy, Physical Medicine, and Occupational Therapy)	Plan pays 100% after deductible	Plan pays 50% after deductible
Lab and X-ray	Plan pays 100% after deductible	Plan pays 50% after deductible
Urgent Care	Plan pays 100% after deductible	Plan pays 50% after deductible
Emergency Room	Plan pays 100% after deductible	Plan pays 100% after deductible
Inpatient Hospitalization	Plan pays 100% after deductible	Plan pays 50% after deductible
Outpatient Surgery	Plan pays 100% after deductible	Plan pays 50% after deductible
PRESCRIPTION DRUGS		
Deductible	Prescriptions subject to medical deductible	Combined with in-network
Annual Out-of-Pocket Maximum	Prescriptions subject to medical out-of-pocket	Out of network claims do not apply to out-of-pocket limit
Retail-30 Day Supply Generic Preferred Brand Non-Preferred Brand	 Plan pays 100% after deductible Plan pays 100% after deductible Plan pays 100% after deductible	 Plan pays 50% after deductible Plan pays 50% after deductible Plan pays 50% after deductible
Mail Order- 90 Day Supply Generic Preferred Brand Non-Preferred Brand	 Plan pays 100% after deductible Plan pays 100% after deductible Plan pays 100% after deductible	 N/A N/A N/A

LiveHealth Online

MID YEAR CHANGES

- You have year-round access to a summary of your benefits through LiveHealth Online.
- Mid year changes should be initiated through LiveHealth Online-HR may reach out for additional verification.

LiveHealth Online

Have a health questions? Under the weather? With LiveHealth Online, you don't have to schedule an appointment, drive to the doctor's office, and then wait for an appointment. In fact, you don't even have to leave your home or office. Doctors can answer questions, make a diagnosis and even prescribe basic medications when needed.

With Live Health Online you get:

- Immediate doctor visits through live video
- Your choice of U.S. board-certified doctors
- Subject to deductible, office copays, and coinsurance
- Private, secure and convenient online visits.

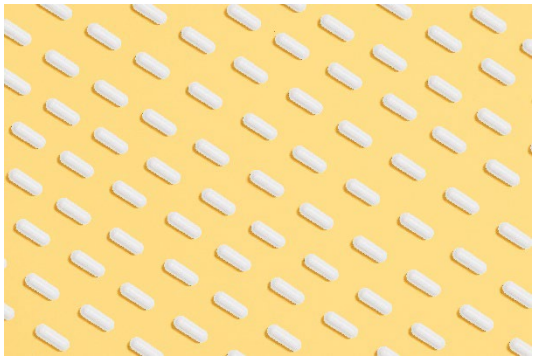
Getting started

- Enroll for free at www.livehealthonline.com

1. Choose **Sign Up** to create your LiveHealth Online account. Then enter information like your name, email, address, date of birth, and create a secure password.
2. Read the *Terms of Use* and check the box to agree.
3. Choose your location in the drop-down box of states
4. Enter your birth date and choose your gender
5. For the question "Do you have insurance?", select **Yes**. Be sure to have your Anthem member ID card handy to complete your insurance information. If you choose **No**, you can still enter your insurance information later.
6. For **Health Plan**, in the drop-down box, select **Anthem**.
7. For **Subscriber ID**, enter your identification number, which is found on your Anthem member ID card. Select **Yes** if you are the primary subscriber or **No** if you are not the primary subscriber
8. Insert a service key if you have one. If you don't have a service key that's OK, this is optional and not required to register
9. Select the green **Finish** button. **LiveHealth** Online Sign up today – so you're ready for a video visit when you need it.

NEW!

PRESCRIPTION DRUGS FOR BLUE SHIELD MEMBERS– NAVITUS



MANAGE YOUR MEDICATION. ANYTIME. ANYWHERE.

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

Blue Shield members have access to prescription drug coverage through Navitus. Below is some information to keep in mind regarding this coverage:

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.

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, such as Walgreens®, 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.

HEALTH SAVINGS ACCOUNT (HSA)

Click to play video

WHAT IS A HEALTH SAVINGS ACCOUNT (HSA)?

An HSA is a tax-free savings account that works with a qualified health plan to help you pay for the cost of out-of-pocket health care and prescription medication expenses. You take the money you would have paid for higher health insurance premiums and use it to pay for qualified medical expenses or save it and let it grow! What's more:

Your HSA money is yours, ALWAYS! You won't lose it if you don't spend it, change jobs, retire or change health plans.

- You never pay taxes on withdrawals for qualified medical expenses.
- Your money earns interest and you don't pay taxes on the interest earned.
- Your contributions are tax-free and reduce your overall taxable income. (Non-Applicable in CA)
- You can change your contribution to the HSA any time during the year.

WHO IS ELIGIBLE FOR AN HSA?

Anyone meeting the following requirements is eligible for an HSA:

- Is enrolled in Sutter County's Anthem Blue Cross Medical PPO HDHP 3400,
- Is not covered under another medical plan that is not HSA compatible,
- Is not enrolled in Medicare,
- Is not eligible to be claimed on another person's tax return,
- Is not active in the military, and
- Is a U.S. resident.

2026 HSA CONTRIBUTION LIMIT

Individual Limit - $4,300

Family Limit - $8,550

Catch up for participants age 55 or older - $1,000

You are allowed to contribute the entire year's limit when you first become eligible for the HSA (even if that is in December); however, you must remain eligible for at least 12 months after that date, or you will be subject to taxes and penalties on the amount you contributed.

NOTE: If you elect the Anthem Blue Cross Medical PPO HDHP 3400 with a Health Savings Account, you cannot participate in the Traditional Healthcare FSA.

If you use HSA funds for non-qualified expenses before you are age 65, you will owe a 20% penalty tax PLUS income tax on the withdrawal. After age 65, if you use HSA funds for non-qualified expenses, you will owe income tax only.

Please note that contributions can be deducted from your federal taxes, but not from your California state taxes.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

The Flexible Spending Account (FSA) offered through BCC allows you to pay for eligible healthcare and dependent care expenses using tax-free dollars. When you participate in an FSA plan via salary reduction, you reduce your federal, FICA, social security, Medicare (and in some cases, state) taxes and increases take-home pay. The money that is deposited into your FSA comes straight out of your gross pay, therefore reducing your taxes.

Click to play video

DIRECT DEPOSIT

Your FSA reimbursements can be deposited directly into your checking or savings account with each transaction being reflected on the Explanation of Benefits. This optional feature is available by selecting and completing the direct deposit payment method in My SmartCare or by completing the authorization form available from your HR Department and following the submission instructions on the form.

CUSTOMER SERVICE

BCC's call center is comprised of knowledgeable, licensed agents that are ready to answer your FSA questions. Call us toll-free at (800) 685-6100. Agents are available Monday – Thursday from 5:00am – 5:00pm PT and Friday from 5:00am – 3:00pm PT.

HEALTH CARE FSA

This plan allows you set aside pre-tax dollars to help pay for certain out-of-pocket health care expenses. Contributions are made annually and limited to $3,400 per year. This plan offers a benefit debit card for your convenience.

Health FSA Eligible Expenses:

- Medical expenses; co-pays, co-insurance, and deductibles
- Dental expenses; exams, cleanings, X-rays, and braces
- Vision expenses; exams, contact lenses and supplies, eyeglasses, and laser eye surgery
- Professional services; chiropractor and acupuncture
- Prescription drugs and insulin

NOTE: If you elect the Anthem (HDHP) with Health Savings Account, you cannot participate in the Traditional Healthcare FSA.

LIMITED PURPOSE FSA

If you elect the Anthem Medical PPO HDHP 3400 with a Health Savings Account, you cannot participate in the Traditional Healthcare FSA, you must choose a Limited Purpose Healthcare FSA. This plan allows you to use your pretax dollars to pay for eligible Dental and Vision expenses only. Contributions are made annually and limited to $2,750 per year.

LIMITED PURPOSE FSA ELIGIBLE EXPENSES:

- Dental cleaning
- Dental fillings
- Dental crowns
- Braces
- Contact lenses
- Eyeglasses
- Eye exams
- Vision correction (Lasik)

Mail:	Fax:	E-Mail:	Download:
Benefit Coordinators Corporation, Attn: FSA Two Robinson Plaza, Ste. 200 Pittsburgh, PA 15205	(412) 276-7185	fsa-claims@benxcel.com *PDF files only* *Attachments cannot exceed 5MB*	https://secure.benxcel.com

DENTAL

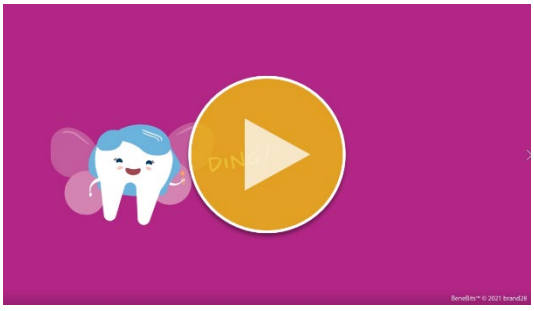
OUR PLANS

DeltaCare HMO

PPO Plus Premier 1000

PPO Plus Premier 2000

Click to play video



We offer 3 plans through Delta Dental.

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 four 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 DELTACARE HMO

Sutter County provides you with comprehensive coverage through Delta Dental of California. The County offers both a DHMO and PPO Options.

Regular visits to your dentists can protect more than your smile; they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes, and heart disease.

Here is an overview of our DHMO plan offered through Delta Dental of California.

	In-Network
Calendar Year Deductible	$0 per individual $0 per family
Annual Plan Maximum	Unlimited
Waiting Period	N/A
Diagnostic and Preventive	$0-$45 copay (varies by services, see contract for fee schedule)
Basic Services	
Fillings	$0-$85 copay (varies by services, see contract for fee schedule)
Root Canals	$0-$280 copay (varies by services, see contract for fee schedule)
Periodontics	$0-$280 copay (varies by services, see contract for fee schedule)
Major Services	$0-$240 copay (varies by services, see contract for fee schedule)
Orthodontic Services	
Orthodontia	Call DeltaCare for more information
Lifetime Maximum	Unlimited

DELTA DENTAL PPO

Our PPO network dentists accept reduced fees for covered services they provide you, so you'll usually pay the least when you visit a PPO network dentist. This also ensures Delta Dental PPO dentists won't balance bill you the difference between the contracted amount and their usual fee.

Here is an overview of our DPPO plans offered through Delta Dental of California.

	PPO Plus Premier 1000		PPO Plus Premier 2000	
	PPO-Network	Premier and Out-of-Network	PPO-Network	Premier and Out-of-Network
Annual Deductible	$50 per individual $100 per family		$50 per individual $100 per family	
Annual Plan Maximum	$1,000 per individual		$2,000 per individual	
Waiting Period	None	None	None	None
Diagnostic & Preventive	Plan pays 100% deductible waived	Plan pays 100% deductible waived	Plan pays 100% deductible waived	Plan pays 100% deductible waived
Basic Services Fillings Root Canals Periodontics	Plan pays 85% after deductible	Plan pays 85% after deductible	Plan pays 85% after deductible	Plan pays 85% after deductible
Major Services	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible	Plan pays 50% after deductible
Orthodontia	Plan pays 50% deductible waived		Plan pays 50% deductible waived	
Ortho Lifetime Max	$1,000 (Dependent Children Only)		$2,000 (Adults and Dependent Children)	

Customer Service (800) 765-6003
Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330
www.deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your Plan.

VISION

OUR PLANS

VSP Vision Core Plan PRISM

VSP Vision Buy-Up Plan PRISM

Click to play video

We offer 2 vision plans through VSP.

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.

Notes/Comments: Vision benefits are based on a 12 month service year, not a calendar year. This means that you are not eligible for another exam, new lenses, frames or contacts until at least 12/24 months have passed since you received services.

*When you choose contacts instead of glasses, your $130 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts.

VSP VISION CORE PLAN

Routine vision exams are important, not only for correcting vision but because they can detect other serious health conditions.

VSP provides participants with access to a large network of vision care providers. To locate a network provider visit www.vsp.com. If you decide not to see a VSP doctor, the plan co-pay still applies. This choice is yours—either way, your VSP benefits are a tremendous part of your overall benefits package. There are no ID cards necessary for this plan

	VSP Vision Core Plan PRISM	
	In-Network	**Out-of-Network**
Exams Benefit Frequency	$20 copay Once every 12 months from last date of service	Reimbursed up to $45 In-network limitations apply
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	Plan pays 100% of basic lens (copay applies) Plan pays 100% of basic lens (copay applies) Plan pays 100% of basic lens (copay applies) Once every 12 months from last date of service	Reimbursed up to $30 Reimbursed up to $50 Reimbursed up to $65 In-network limitations apply
Frames Benefit Frequency	$130 allowance, additional 20% discount on remaining balance Once every 24 months	Reimbursed up to $70 In-network limitations may apply
Contacts (Elective) Benefits Frequency	$130 allowance, plus 15% discount on a contacts lens exam (copay waived; instead of eyeglasses) Once every 12 months from last date of service	Reimbursed up to $105 (in-network limitations apply) In-network limitations apply

VSP VISION BUY- UP PLAN

	VSP Vision Core Plan PRISM	
	In-Network	**Out-of-Network**
Exams Benefit Frequency	$10 copay Once every 12 months from last date of service	Reimbursed up to $45 In-network limitations apply
Eyeglass Lenses Single Vision Lens Bifocal Lens Trifocal Lens Frequency	Plan pays 100% of basic lens (copay applies) Plan pays 100% of basic lens (copay applies) Plan pays 100% of basic lens (copay applies) Once every 12 months from last date of service	Reimbursed up to $30 Reimbursed up to $50 Reimbursed up to $65 In-network limitations apply
Frames Benefit Frequency	$150 allowance, additional 20% discount on remaining balance Once every 12 months	Reimbursed up to $70 In-network limitations may apply
Contacts (Elective) Benefits Frequency	$150 allowance, plus 15% discount on a contacts lens exam (copay waived; instead of eyeglasses) Once every 12 months from last date of service	Reimbursed up to $105 (in-network limitations apply) In-network limitations apply

Notes/Comments: Vision benefits are based on a 12 month service year, not a calendar year. This means that you are not eligible for another exam, new lenses, frames or contacts until at least 12/24 months have passed since you received services.

*When you choose contacts instead of glasses, your $130 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts.

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, 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-term disability and a base amount of life and AD&D insurance options 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.

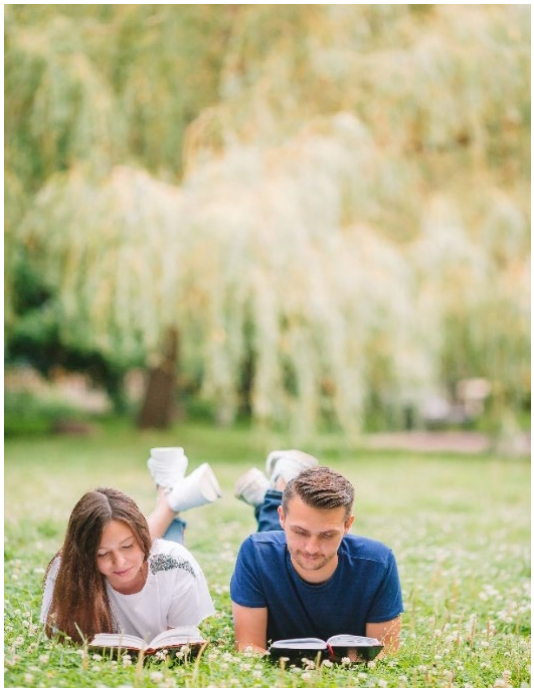
LIFE AND AD&D INSURANCE

Protecting those you leave behind

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security.

Basic Life and AD&D

Basic Life Insurance pays your beneficiary a lump sum if you die. AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you die in an accident. The cost of coverage is paid in full by the County. Basic Life and AD&D coverage is also provided to your dependents as well. Coverage is provided by Lincoln Financial Group.



Lincoln Financial Voluntary Life Insurance

Employee	$10,000 Minimum, up to a maximum of $250,000 (not to exceed 5x annual earnings) Guaranteed Issue: $70,000
Spouse	$10,000 minimum, up to a maximum of $250,000 (not to exceed 100% of employee's benefit) Guaranteed Issue: $20,000
Child(ren) (over 6 months old)	$1,000 minimum, up to a maximum of $10,000 (not to exceed 50% of employee election)

In the event of a serious or fatal accident

Voluntary AD&D Insurance allows you to purchase accidental death and dismemberment coverage that pays your beneficiary if you have a fatal accident. If you experience a serious injury such as a loss of a limb, speech, sight or hearing, the plan pays a benefit to you.

Coverage is provided by Lincoln Financial Group and is available for your spouse and/or child(ren).

Monthly Rates per $1,000	Employee / Dependent Rates
Under age 20	$0.094
Age 20-24	$0.094
Age 25-29	$0.094
Age 30-34	$0.094
Age 35-39	$0.094
Age 40-44	$0.198
Age 45-49	$0.349
Age 50-54	$0.567
Age 55-59	$0.878
Age 60-64	$1.320
Age 65-69	$1.980
Age 70-74	$1.980
Age 75+	$1.980
Dependent Child(ren) Rates	$0.260

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.

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 programs 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. Be sure to take advantage of these programs to stay at your best.

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 Blue Shield 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 Blue Shield (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 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.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

CONTACT THE EAP

With Anthem EAP, you have access to virtual visits through LiveHealth Online. You can access LiveHealth Online by visiting the website at www.livehealthonline.com or by downloading the app from the Apple or Google app store.

ANTHEM EAP SERVICES ARE ACCESSIBLE 24-HOURS A DAY. TOLL-FREE (833) 954-1067 OR ONLINE AT ANTHEMEAP.COM (ACCESS CODE: PRISM)

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 Anthem can help you handle a wide variety of personal issue 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

You and your household members are entitled to 6 face-to-face sessions or telephonic or online consultations for problem-solving support per individual, per incident, per policy year.

All services are confidential and in accordance with professional ethics and federal and state laws. Use of the EAP is strictly voluntary.

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

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 $3,250 per household per year. If you are married but filing separately, federal regulations limit the use of Dependent Care FSA to $3,250 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.

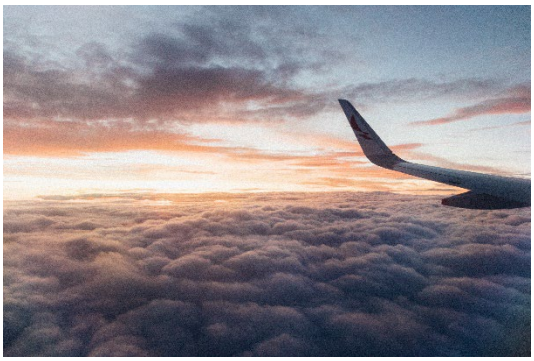
Estimate carefully! You can’t change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

BUSINESS TRAVEL ACCIDENT

Extra protection while traveling for business

Business travel insurance provides a variety of benefits to assist you while you're traveling for business.

while traveling 100 or more miles from home (see your plan for details). Whether traveling for business or leisure, if you are enrolled in the life and/or AD&D plan, you and your loved ones can count on TravelConnect for responsive and caring support, 24 hours a day, 7 days a week.



Make travel less stressful. TravelConnect can assist you with:

- Emergency pet boarding and/or return
- Return of traveling companion
- ID recovery assistance
- Vehicle return
- Emergency travel arrangements
- Lost or stolen travel documents
- Language translation services
- Medical and dental referrals
- Corrective lens and medical device replacement
- Medication and vaccine delivery
- Evacuation coordination for an emergency security or political event, or natural disaster*
- Destination information

*On Call International must coordinate and provide all arrangements for eligible services to be covered. Coverage is subject to contract language that contains specific terms, conditions and limitations

To learn more, call 866.525.1955 (U.S.) or 603.328.1955 (Outside U.S.)
mysearchlightportal.com
code: LFGTravel123

LIFE ASSISTANCE PROGRAM

In-Person Guidance

Some matters are best resolved by meeting with a professional in person. With EmployeeConnect, you and your family get:

- In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year)
- In-person consultations with network lawyers, including on free 30-minute in-person consultation per legal issue, and 25% off subsequent meetings.

Unlimited Assistance 24/7

You and your family can access the following services anytime – online, on the mobile app or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning and more
- Legal information and referrals for family law, estate planning, consumer and civil law
- Financial guidance on household budgeting and short – and long-term planning

Online Resources

EmployeeConnect offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are a just a click away when you visit www.guidanceresources.com or download the GuidanceNow mobile app. You'll find

- Articles and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets and more.

EmployeeConnect Assistance Program – 24/7 support
888.628.4824
www.guidanceresources.com
Login: LFGSupport
Password: LFGSupport1

ONLINE WILL PREPARATION

Having a will allows you to designate who will receive your property and assets when you're gone. Without one, your state determines how your estate is distributed. Online will preparation services are available with LifeKeys services, which is included with your life insurance policy from Lincoln Financial Group. EstateGuidance will preparation is a quick and easy way to create and execute a will.

Online will preparations allows you to document your final wishes, such as

- Beneficiaries to inherit property
- Naming a guardian to care for minor children

Online will preparation is straightforward

- Create, save and print a legally binding will that you can change at any time.
- Detailed instructions and definitions guide you through the process.
- All personal legal forms and documents are stored on a secure server and are only accessible via password.
- You can make unlimited revisions at no cost.

Getting started is easy

1. Go to https://www.estateguidance.com/ and click “Get Started” at the top to begin.
2. Create your account and enter “Lifekeys” in the Promotional Code field to receive the discounted products.
3. Click “Get Started” under Last Will and Testament
4. Answer the preliminary questions. You can add a Living Will or Final Arrangements for an addition cost. Click “get Started” to proceed.
5. Enter your personal information and click “Next” to move through all 8 sections (Personal, Family, Estate, Gifts, Remainder, Minors, Legal Rep and Other)
6. Congratulations, you’ve completed your will! You can download the document to your computer or have it emailed to you for free or request a printed copy at a cost.

Be sure to sign and date your Last Will and Testament in the presence of qualified witnesses and a notary public, as detailed at EstateGuidance.com.

Visit the website today

For help, call **855.891.3684**.*

*No legal advice is provided

VOLUNTARY PLANS

OUR VOLUNTARY PLANS

Accident Insurance

Critical Illness Insurance

Hospital Indemnity Insurance

Short-Term Disability Insurance

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

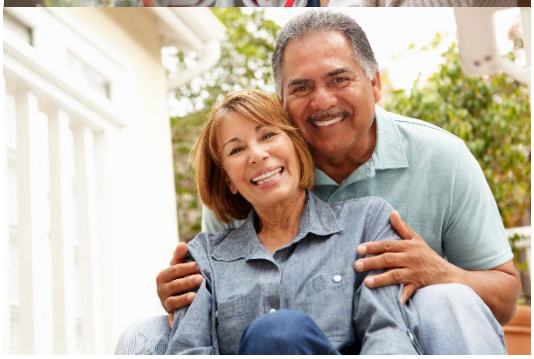
Sutter County offers plans to help:

- replace income if you're injured or ill
- bridge the gap for special healthcare needs
- secure your identity, and help you manage legal issues

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. Or, you don't have to sign up for voluntary benefits at all. The choice is yours.

VOLUNTARY HEALTH-RELATED PLANS



Accident Insurance

If an accident occurs, you may be surprised at how quickly expenses can add up. Accident insurance helps offset unexpected medical expenses, such as emergency room fees, deductibles and co-payments that can result from a fracture, dislocation or other covered accidental injury

Critical Illness Insurance

Critical illness insurance supplements your major medical coverage by providing a lump-sum benefit that you can use to pay the direct and indirect costs related to a covered critical illness, such as cancer, heart attack (myocardial infarction), end-stage renal (kidney) failure or stroke. Guaranteed issue amounts available for all covered insureds. Pre-existing and other exclusions still apply with guaranteed issues policies.

Hospital Indemnity Insurance

Does your major medical insurance cover all your bills? Even a minor trip to the hospital can present you with unexpected expenses and medical bills. Hospital confinement indemnity insurance provides a lump-sum benefit for a covered hospital confinement to help with deductibles and other expenses that are not covered by most major medical plans. Guaranteed issue amounts available for all covered insureds. Pre-existing and other exclusions still apply with guaranteed issues policies.

Short-Term Disability

Short-term Disability insurance replaces a portion of income if a covered accident or sickness prevents you from earning a paycheck. This insurance can provide a monthly benefit to help cover any ongoing expenses, including necessities like food and housing.

Guaranteed issue amounts are available. Employee only coverage. Pre-existing and other exclusions still apply with guaranteed issue policies.

Open Enrollment: If you have questions about how voluntary benefits from Colonial Life can help with out-of-pocket medical expenses, such as deductibles and copays, or to apply, please contact:

The Colonial Life Enrollment Center

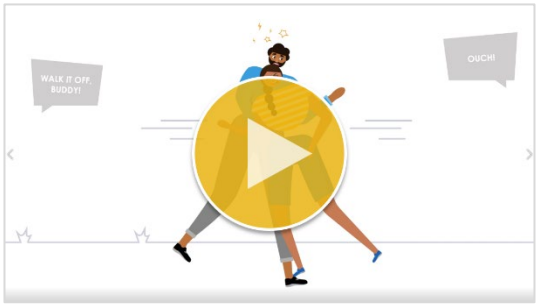
Toll-free: 855-697-6876

Please leave your name, employer and contact phone number. A Colonial Life benefits counselor will reach out to you to arrange a virtual enrollment session.

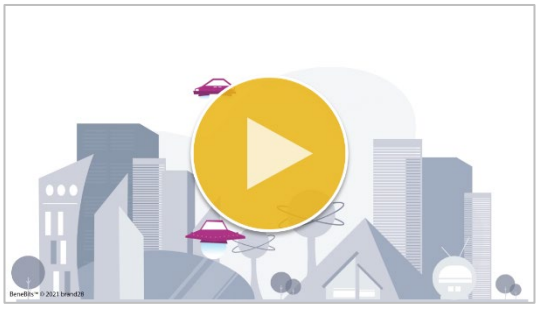
Colonial Life

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

Health Enhancing Programs

In addition to medical coverage, we provide these programs and services to help you access care when and how you need it and address special health concerns:

- **Sydney –** Anthem mobile app
- **Livongo** – Manage diabetes
- **Lark** – Helping you manage your risk for diabetes

PRISM Anthem Resources

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 Management Program

Available to participants of HDHP 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

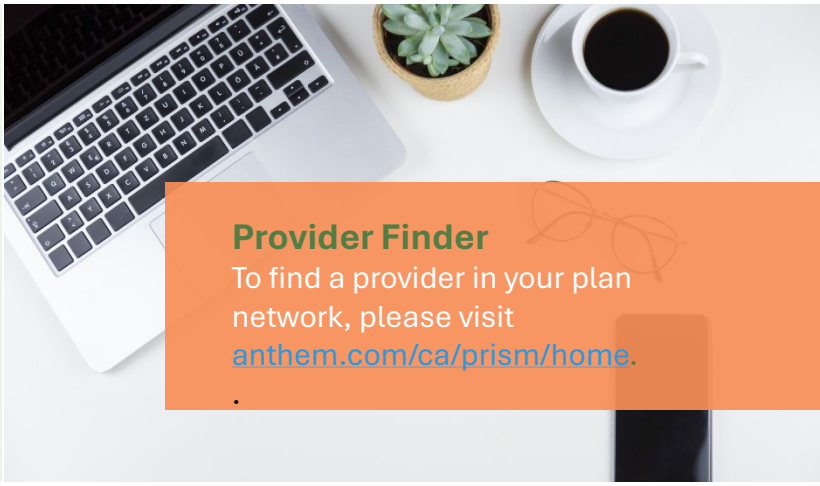
Through Anthem's LiveHealth Online Virtual Primary Care (LHO VPC), members can choose from board-certified, in-network PCPs, and have that same doctor take care of them overtime for treatments including chronic conditions, preventative care, and acute care, at no extra cost to the member. Copay will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

Anthem ID Cards

For PPO and HDHP 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.



Provider Finder

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

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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 (833) 574-2273 (SoCal) or (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®.

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 Cancers.	**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.	**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.	**Members Call:** (888) 799-2553 **Pharmacies Call:** (844) 857-4351 **Visit** gold.goodrx.com

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 Sutter County if your domestic partner is your tax dependent.

PLAN CONTACTS

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

Plan Type	Provider	Phone Number	Website
Medical PPO	Anthem Blue Cross	(800) 967-3015	www.anthem.com/ca/prism
Medical HMO	Kaiser	(800) 464-4000	www.kp.org
Pharmacy Rx	Navitus	(866) 333-2757	www.navitus.com
Dental	Delta	(888) 335-8227	www.deltadentalins.com
Vision	VSP	(800) 877-7195	www.vsp.com
Life/AD&D	Lincoln Financial	(800) 423-2765	www.lincolnfinancial.com
EAP	Anthem	(833) 954-1067	www.anthemeap.com
FSA	BCC	(800) 685-6100	www.benxcel.com/
H.S.A.	Anthem Actwise	(844) 860-3731	www.anthem.com/ca
Voluntary Benefits	Colonial Life	(800) 325-4368	www.coloniallife.com

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 County of Sutter 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 Sutter 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 Sutter has determined that the prescription drug coverage offered by the County of Sutter, 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 Sutter 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 the County of Sutter 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.

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 your plan administrator

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

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in County of Sutter 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 Sutter 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 Sutter 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.

Michelle's Law

The County of Sutter 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, Human Resources 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, 2025**. 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: 1-844-854-4825
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 July 31, 2025, 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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 9.96% in 2026 of your modified adjusted household income.

Rules for Benefit Changes During the Year

Other than during annual open enrollment, you may only make changes to your benefit elections if you experience a qualified status change or qualify for a "special enrollment". If you qualify for a mid-year benefit change, you may be required to submit proof of the change or evidence of prior coverage.

Qualified Status Changes Include:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, and death of a spouse
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child
- Change in employment status that affects benefit eligibility, including the start or termination of employment by you, your spouse, or your dependent child
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full- time employment or ceasing to satisfy them
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- Change in place of residence or worksite, including a change that affects the accessibility of network providers
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child
- An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA) including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan.
- An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act. Under provisions of the Act, employees have 60 days after the following events to request enrollment:

  Employee or dependent loses eligibility for Medicaid (known as Medi-Cal in CA) or CHIP (known as Healthy Families in CA).

  Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP

Two rules apply to making changes to your benefits during the year:

Any changes you make must be consistent with the change in status, AND

You must make the changes within 31 days of the date the event (marriage, birth, etc.) occurs (unless otherwise noted above.


SUTTER
COUNTY