2023

Employee Benefits Guide

LET YOUR HEALTH GLOW

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Medicare Part D Notice: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Annual Notices on page 32 for more details.

Let your health glow

At Tehama County, we value your contributions to our success and want to provide you with a benefits package that protects your health and helps your financial security, now and in the future. We continually look for valuable benefits that support your needs, whether you are single, married, raising a family, or thinking ahead to retirement. We are committed to giving you the resources you need to understand your options and how your choices could affect you financially.

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

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

The benefits in this summary are effective:

January 1, 2023 - December 31, 2023

Who Can You Cover?

WHO IS ELIGIBLE?

In general, regular employees working 20 or more hours per week are eligible for the benefits outlined in this overview. In order to comply with the Affordable Care Act (ACA), Tehama County generally determines your eligibility for benefits using the Look-Back Measurement Method. Refer to the Look-Back Measurement Method section of this guide for additional information on how your eligibility is determined.

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 domestic partner is eligible for coverage if you have completed a Domestic Partner Affidavit. Please review the affidavit guidelines. The Cost of Coverage section explains the tax treatment of domestic partner coverage.
- Your children (including your Domestic Partner):
    - Under age 26 are eligible to enroll in medical 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.
    - Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.
    - Named in a Qualified Medical Child Support Order (QMCSO) as defined by federal law.

Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

WHO IS NOT ELIGIBLE?

Family 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.

ENROLLMENT PERIODS

Coverage for new full-time employees begins on the 1st of month following 30 days. New employees who do not make an election within 31 days of becoming eligible will need to sign a waiver declining coverage.

After that, Open Enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Notify Personnel (not Human Resources) within 31 days if you have a qualifying life event and need to add or drop dependents outside of Open Enrollment. Life events include (but are not limited to):

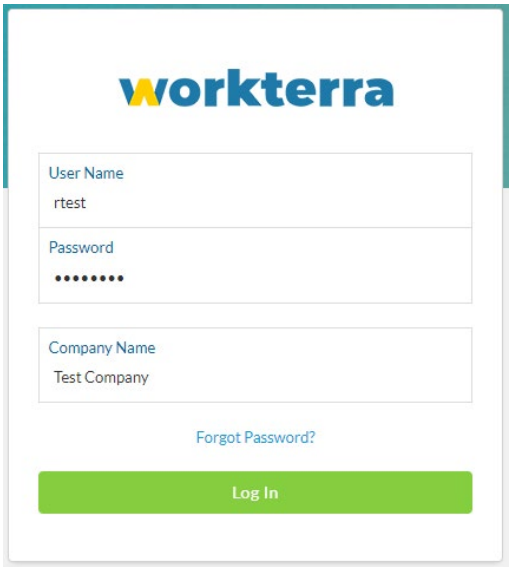
- Birth or adoption of a baby or child
- Loss of other healthcare coverage
- Eligibility for new healthcare coverage
- Marriage or divorce

Employee Self-Service Instructions

Workterra is a tool that allows you to directly access and update your employee information via the Internet. Using Workterra employee self-service, you can review and/or update your demographic, dependents, and benefit elections.

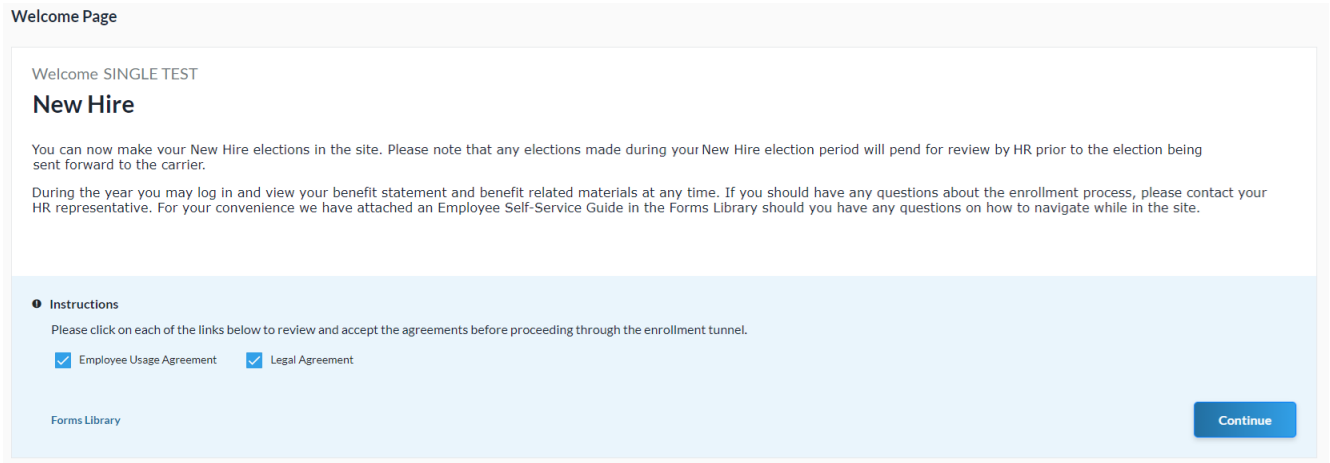
- You can access Workterra from any computer with an internet connection. Our secure (https) site uses the latest technology to ensure that the information entered is secure and adheres to Workterra and industry security standards.
- If you are having trouble logging into the site, Workterra Customer Service is here to help with password resets and site technical expertise. Customer Service is available Monday-Friday 8am-5pm Pacific Time 888-327-2770 or customerservice@workterra.com.

Logging In



1. Launch an Internet browser such as Chrome or Internet Explorer and turn off all “Pop-Up Blockers”.
2. Navigate to https://www.workterra.net
3. Enter the information below and click **Login**
   - **User name:** [first name, last name]
   - **(Example: [janedoner]**

Note: *if you wish to view the site in SPANISH, click on “Espanol (es-mx)” in the drop down box on the top right of the page.*



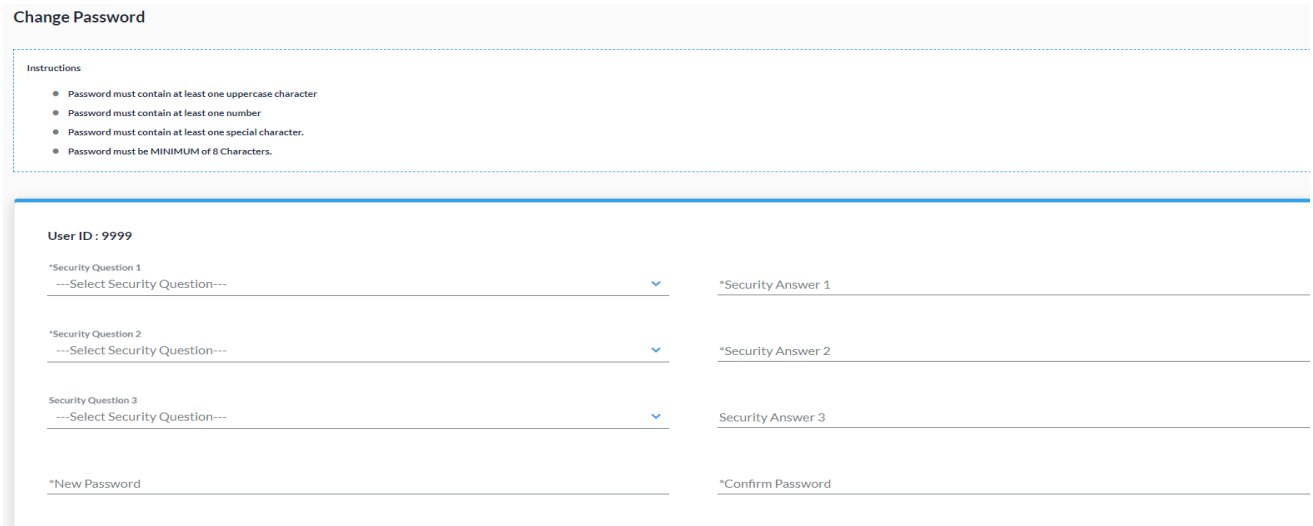
Please read your Welcome Page Information and then click the box next to the **Employee Usage Agreement and Legal Agreement**. Once you have read both, select **Continue.**

Change Password

Please provide your security questions and answers as well as update your password. When finished select **Save** to continue.

Please note your password must be:

- Password must be a minimum of 8 characters.
- Password must contain at least one numeric digit.
- Password must contain at least one special character.
- Password must contain at least one UPPERCASE letter.



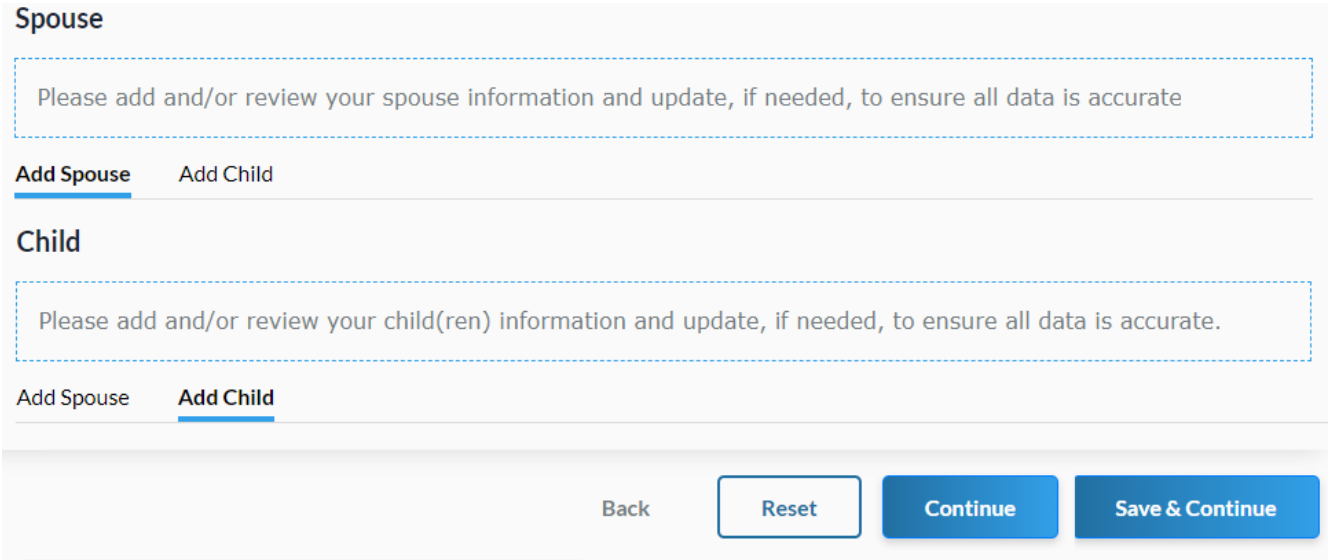
Demographics & Dependents

You will have an opportunity to review, add, or update your demographic, your spouse or child information on the next few pages.

Please note: Grayed out fields are considered "Review Only" fields. Please contact your HR administrator if any changes are needed to these fields.

Please ensure that all dependents that you would like to cover across any benefit (Medical, Dental, Life, Disability, etc…) are entered within these pages.

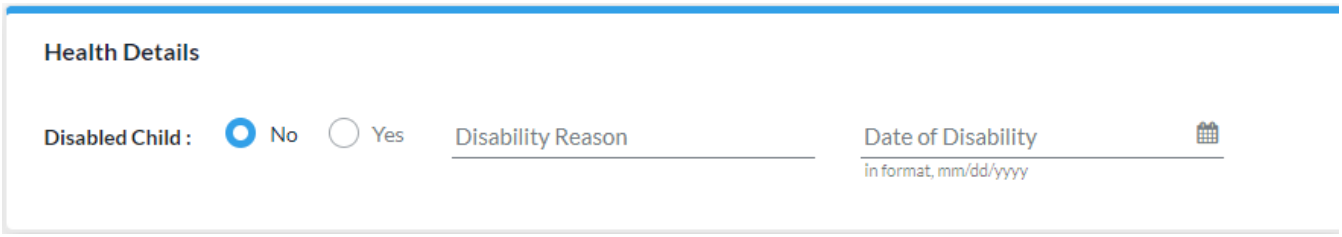
To add a spouse or child, fill out the required fields and click "**Save & Continue**". The screen will open for you to enter their demographic information (required data is marked with a red indicator).



If you have multiple children, select "**Add Another Child**" adding them one at a time and click "**Save & Continue**" once all are added.

If you do not have a spouse or child, click "Continue" to proceed to the next page.

For "**Disabled Children"**, please ensure that you classify the Child Relationship as a "**Disabled Child**" in the Child Relationship box as well as clicking the radial (circle) next to the "**Yes**" in the **Disabled Child** field.

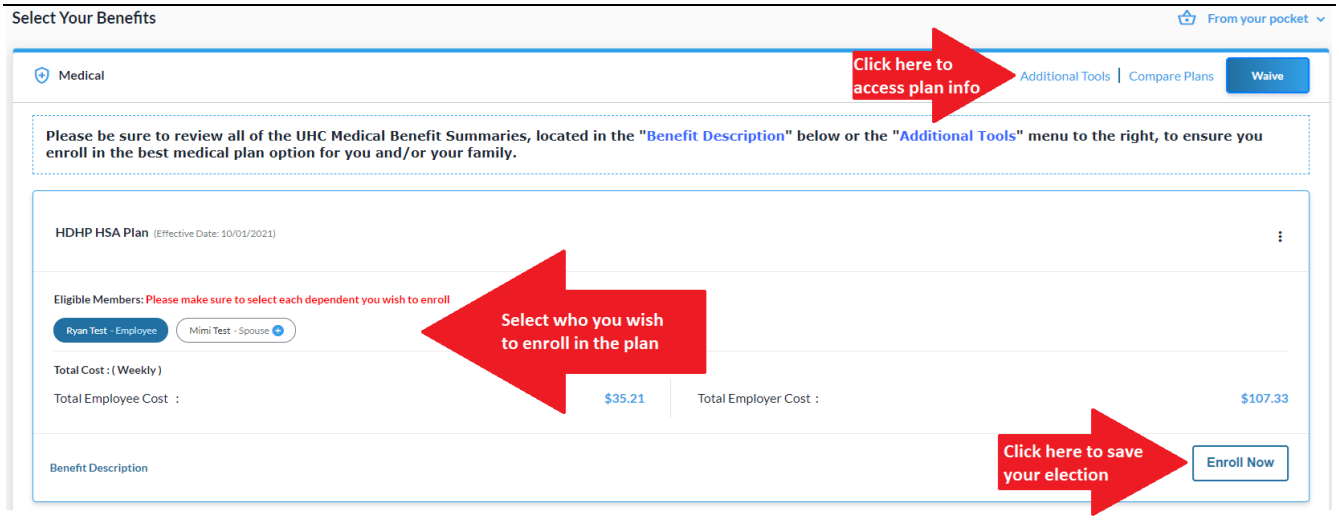


Follow the steps below to enroll in your benefit plans.

If you do not wish to enroll and would prefer to decline the benefit, select "**Waive**".

Please note that the following are available for additional information to assist you in choosing your benefits.

- **Compare Plans**
  - Click the Compare Plans link to the top right of the screen to open up a side-by-side comparison of the plans offered to you.
- **Additional Tools**
  - Click the Additional Tools link to access Learn about your Health/Income Protections, which may contain links to the plan summaries. The Additional Tools link also houses the Forms Library, which may contain additional benefit information and user guides.

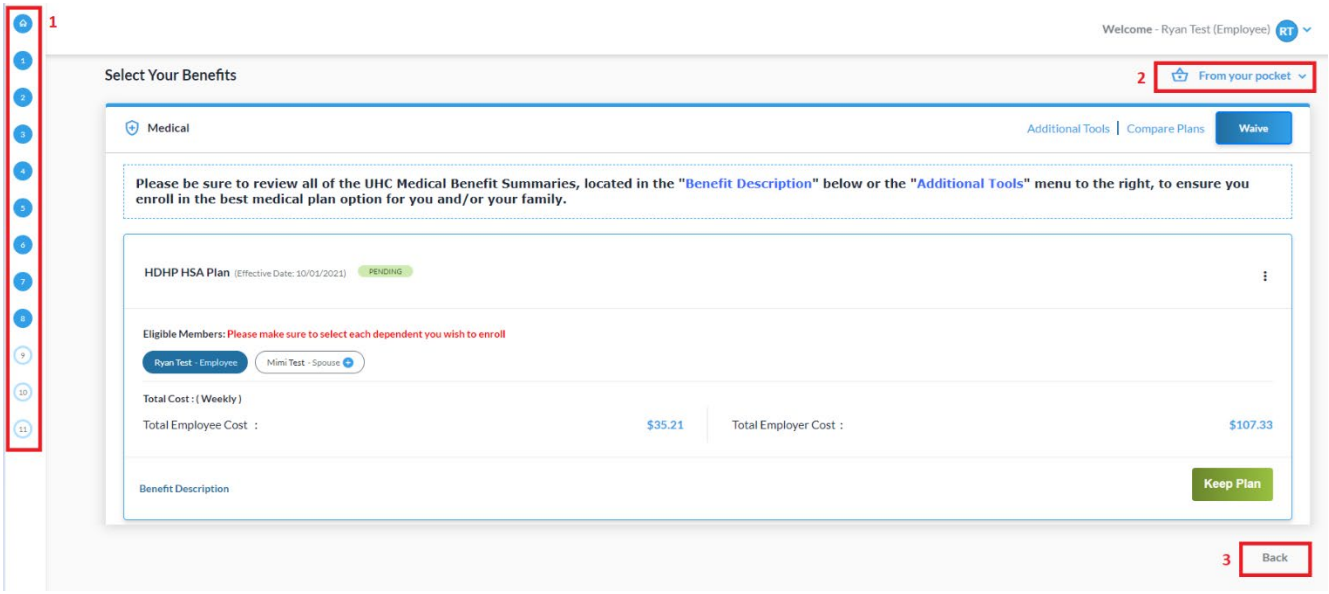


Navigation

Please be sure to use only the navigational buttons provided within the tool. **Do not use your browser's back button**.

You can navigate into previous pages using these three options:

1. The slide out menu bar will allow you to move back to any page that you have previously visited
2. To revisit a plan, you may click on the benefit plan listed in the election summary
3. Use the back button provided by the tool



Adding a new beneficiary:

Your dependents (Spouse and children) that are already entered into Workterra will be in the beneficiary pool.

1. Select your first beneficiary:
    a. To select an existing dependent as a beneficiary, select their name in the drop down
    b. If you would like to add another beneficiary, select the applicable relationship in the drop down menu
        i. A pop up box will appear asking for more information on your new beneficiary. Complete the fields and click done.
2. Enter the percentage for this beneficiary in the "percentage" field

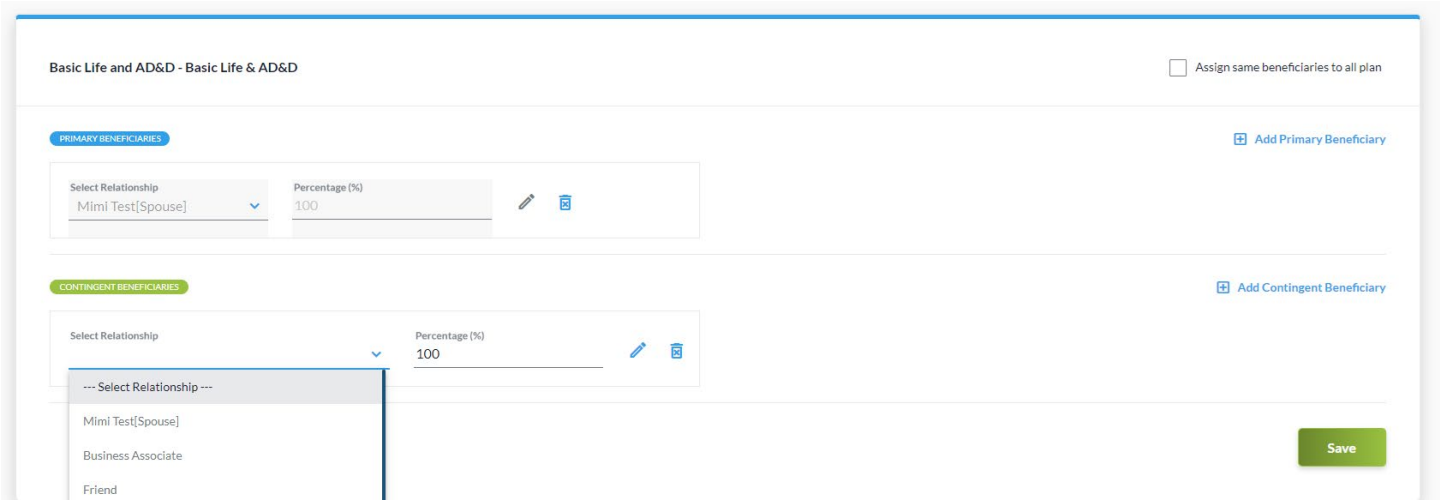
You may also add contingent beneficiaries by clicking on the button "Add Contingent Beneficiary"

Best practices for choosing multiple beneficiaries:

- Use whole numbers when updating the percentage
- Percentages must equal 100
    - For example: 3 beneficiaries should have the percentage of 33, 33, 34

Other tips:

- To add multiple beneficiaries click on the  plus sign
- To remove a beneficiary, click on the  delete icon to the right of the beneficiary name.
- A beneficiary should not be used twice in the same plan.
    - For instance, on the basic life plan, do not have your spouse listed twice as a primary beneficiary.

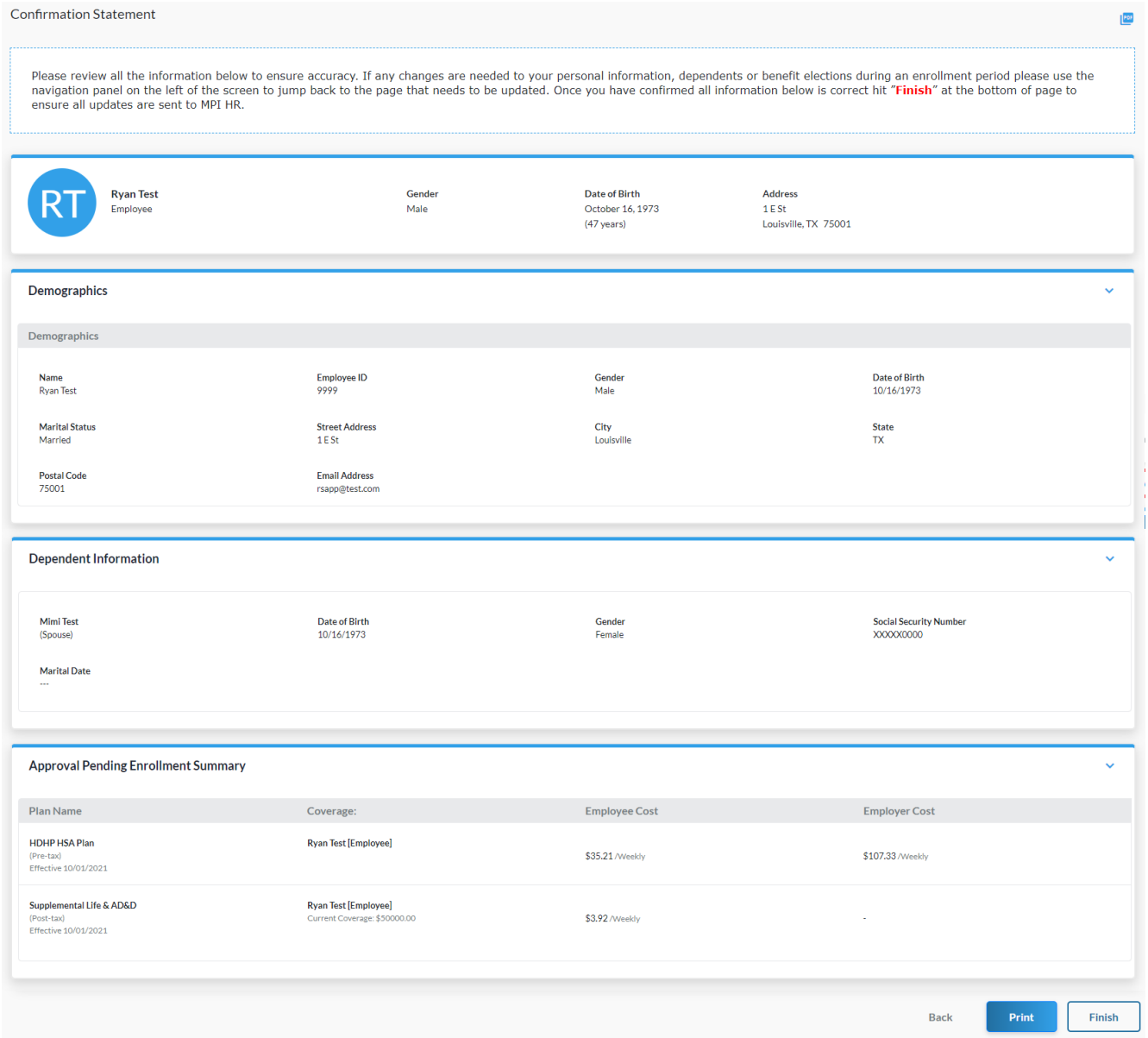


Completing the Enrollment Process

After completing all of your plan elections, you will come to the Confirmation Statement. Please review all of your elections for accuracy.

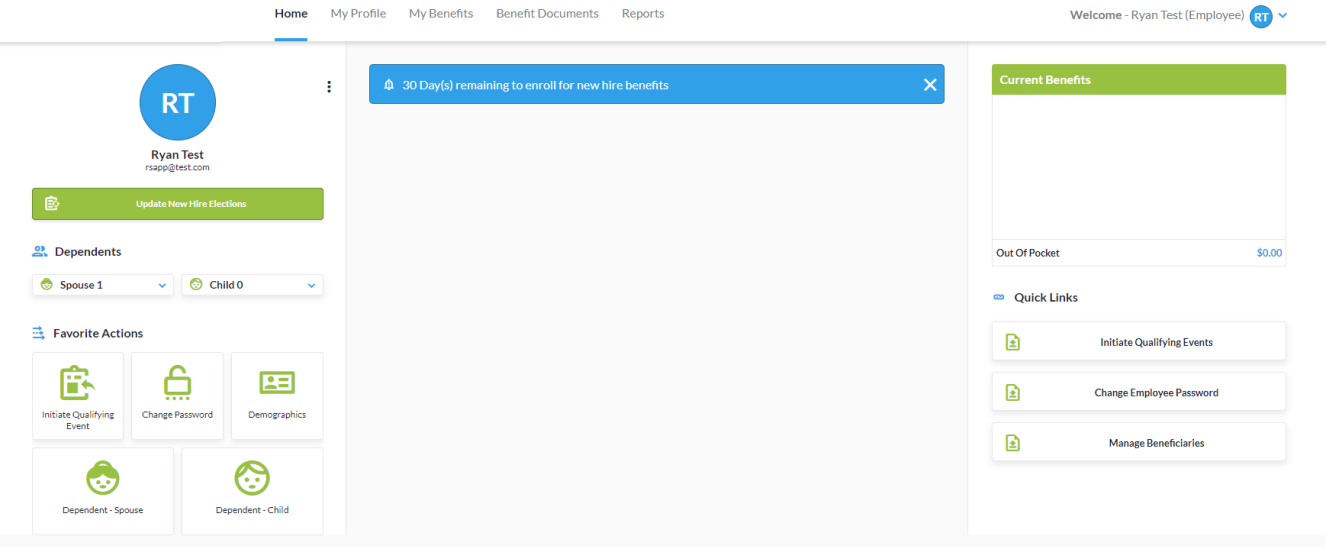
Please be sure to keep a copy of the confirmation statement for your records by clicking on the PDF button to download save & print.

Please click “Finish” at the bottom of the page once you have reviewed your elections. Once you click “Finish”, you will be taken to your Employee Home Page. Your enrollment process is now complete.



(Home Page Navigation & Making Qualifying Event Changes)

Below is an example of your Employee Home Page

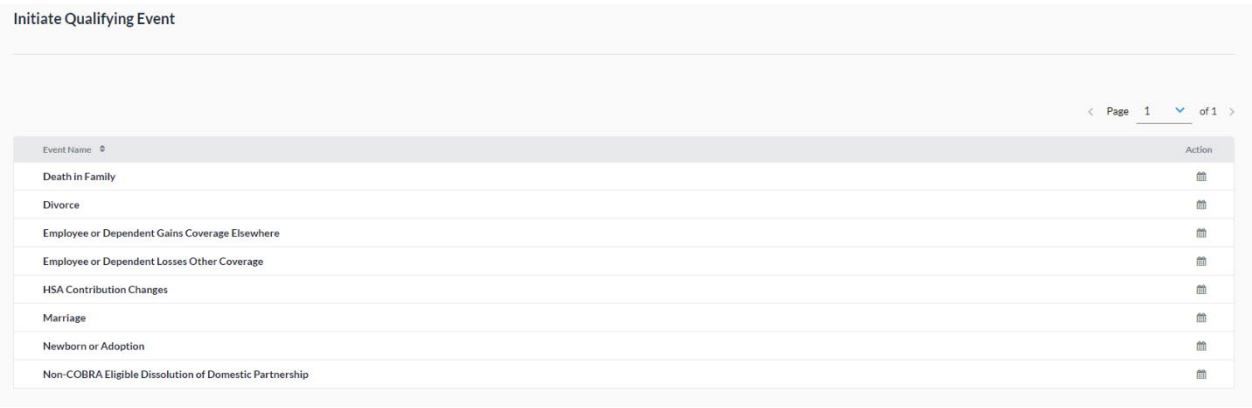


To begin a Qualifying Event (i.e. Marriage, Newborn, Divorce, etc.) click on the "Enroll Now" button found on the Home Page. If an event is not open, you will see an option to open a Qualifying Event by clicking "OK."

Then select the Qualifying Event that applies to you, enter the date of the event, and click "Save". The system will now walk you through your personalized experience.

Please note the following in regards to Qualifying Events:

- To initiate a Qualifying Event, while still within your Open Enrollment period, go to: BenAdmin > Initiate Qualifying Events
- Please ensure the dependent relationship type is updated when processing a Qualifying Event, as this determines eligibility e.g. *If processing a Divorce QE, you must change your spouse relationship type from spouse to ex-spouse. This will ensure that the system will terminate the spouse's benefits and generate the notification for COBRA*.
- During a Qualifying Event, Beneficiary designation will be available after the administrator approves your plan change. To view or change your Beneficiaries outside of an open window, go to: My Benefits > Beneficiary
- During a Qualifying Event, you will have the opportunity to upload the appropriate supporting documents (i.e. marriage certificate, birth certificate, etc.) for your HR Administrator approval. Please be sure to upload your document in the upload document page. **OR** Please be sure to upload your document in the pop up box provided after each change



Medical

Medical coverage provides you with benefits that help keep you healthy, like preventive care screenings and access to urgent care. It also provides important financial protection if you have a serious medical condition.

	Anthem Medical EPO	Anthem Blue Cross Medical PPO	
	In-Network	In-Network	Out-Of-Network
Annual Deductible	$500 Individual / $1,500 Family	$250 Individual / $750 Family	$250 Individual (combined with in-network) $750 Family (combined with in-network)
Annual Out-of-Pocket Max	$3,000 Individual / $9,000 Family	$1,000 per individual $1,000 per individual	$2,000 per individual $2,000 per individual
Lifetime Max	Unlimited	Unlimited	Unlimited
Office Visit			
Primary Provider	$15 copay	$15 copay	Plan pays 60% after deductible
Specialist	$15 copay	$15 copay	Plan pays 60% after deductible
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 60% after deductible (up to $20 per exam)
Chiropractic Care	Plan pays 90% after deductible (up to 24 visits per year)	Plan pays 80% after deductible (combined outpatient rehab limit: up to 24 visits per year)	Plan pays 60% after deductible (in-network limitations apply; up to $25 copay per visit)
Lab and X-ray	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Inpatient Hospitalization	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $600 per day)
Outpatient Surgery	Plan pays 90% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible (up to $350 per day)
Urgent Care	$15 copay	$15 copay	Plan pays 60% after deductible
Emergency Room	$100 copay then plan pays 90% after deductible (copay waived if admitted)	$100 copay then plan pays 80% after deductible (copay waived if admitted)	$100 copay then plan pays 80% after deductible (copay waived if admitted)

LiveHealth Online

Sign up for LiveHealth Online
It's easy and takes just a few minutes!

Using LiveHealth Online, you can have a private and secure video visit with a board-certified doctor or licensed therapist on your smartphone, tablet or computer with a webcam. It's an easy way to get the care you need at home or on the go. When your own doctor isn't available, use LiveHealth Online 24/7 if you have pinkeye, a cold, the flu, a fever, allergies, a sinus infection or other common health condition. A doctor can assess your condition, provide a treatment plan and even send a prescription to your pharmacy, if it's needed.

If you're feeling anxious or having trouble coping on your own and need some support, you can have a video visit with a therapist using LiveHealth Online. Make an appointment in four days or less at livehealthonline.com or on the phone at 1-844-784-8409 from 7 a.m. to 11 p.m., seven days a week. Evening and weekend appointments are available. You can get help for anxiety, depression, grief, panic attacks and more.

LiveHealth Online is available at no cost to those in the EPO and PPO plan.

How to get started

Rather than waiting to sign up when you're not feeling well, register today so you're ready for a visit when you need one. To sign up, visit livehealthonline.com or download the free LiveHealth Online app to your mobile device. Next, you:

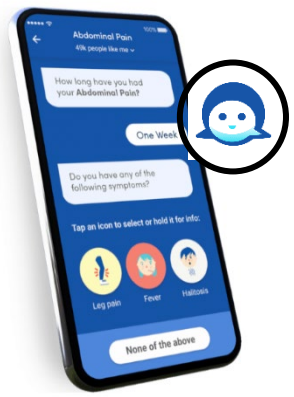
1. Choose **Sign Up** to create your LiveHealth Online account. Then enter information like your name, email address, date of birth and create a secure password.
2. Read the Terms of Use and check the box to agree.
3. Choose your location in the drop-down box of states.
4. Enter your birth date and choose 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.

Anthem BlueCross

LiveHealth ONLINE

Anthem – Mobile App and Value Added Services

SYDNEY – ANTHEM'S MOBILE APP



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

You get one-click access to benefits info, your member ID card and wellness resources. That means you can quickly find what you need.

The more you use it, the more Sydney can help you stay healthy and save money. And Sydney's interactive chat feature can answer your questions in real time.

Find care and check costs, view claims, see your benefits, view your ID card and more!

CONDITIONCARE PROGRAMS

If you or a covered dependent has a chronic health condition, let us help you get the most out of life. Our nurse care managers help people of all ages manage the symptoms of asthma, diabetes and musculoskeletal. With ConditionCare, you'll get the information you need to feel your very best — day after day. Our nurses gather information from you and your doctor and create a plan just for you. To learn more or to enroll in ConditionCare, call Member Services at the number on your ID card.

MEMBER DISCOUNTS

Saving money is good. Saving money on things that are good for you — that's even better. With SpecialOffers, you can get discounts on products and services that help promote better health and well-being. It's just one of the perks of being an Anthem member.

To find the discounts that are available to you, log in to www.anthem.com/CA .

Carrum Health

County of Tehama has partnered with Carrum Health to provide eligible health plan members access to an **enhanced surgery benefit** program with top-quality hospitals and surgeons. Carrum Health is a special surgery benefit that provides exclusive access to Scripps Hospital and Stanford Health Care.

Eligible members include active employees and their dependents who are enrolled in the Anthem PPO plans. Eligible procedures include: hip and knee replacement, spinal fusion surgery, 80 orthopedic procedures (shoulder, elbow, wrist, hand, hip, knee, ankle, foot and spine), multiple spine procedures, coronary bypass (CABG), bariatric (weight loss) surgery. Please contact Carrum Health to learn if your desired procedure is available. Carrum Health recently announced they will offer comprehensive bundles that will cover in-person treatment for eligible patients with breast and thyroid cancers. **Carrum Oncology** will include medical guidance, second opinion services, and treatment services.

Use of this benefit is optional. This benefit is separate from and in addition to the benefits already provided under Anthem. This benefit is not administered by Anthem. This benefit must be accessed through Carrum Health.

Under the Carrum Health surgery benefit program, your personally assigned Carrum "Care Concierge" will:

- Help complete forms
- Gather and transfer medical records
- Assist in the selection of a surgeon
- Schedule the surgery
- Make travel arrangements (if necessary)
- Coordinate post-discharge recovery care

You will have special access to "Centers of Excellence" which are hospitals and surgeons that have been vetted for providing top-quality care and achieving better outcome!

There are no medical bills! Coinsurance and deductibles will be waived!

Travel expenses (if applicable) will be covered for the patient and an adult companion!

To learn more or get started with the program, contact Carrum Health

Toll Free: 1-888-855-7806

Online: carrum.me/prism

Lark Diabetes Prevention Program

Roughly 88 million Americans are living with prediabetes but 84% aren't even aware they have it.1 Prediabetes often doesn't cause symptoms, but it does increase the risk of developing type 2 diabetes, heart disease, and stroke. That's why Anthem has partnered with Lark to offer a diabetes prevention program that can help you determine if you're at risk for prediabetes and if needed, take steps to address it.

Lark's diabetes prevention program includes access to a digital coach. Your coach is available 24/7 to offer friendly, personalized, text message-based coaching through the Lark mobile app. There are no meetings to attend or phone calls to schedule in advance. You can check in whenever and wherever it is convenient for you, right from your smartphone. As part of the program, you will also receive a wireless scale that uploads your information to the app automatically so you can easily track your progress and share it with your coach. Lark will even send you a personal activity tracker, as long as you stay active in the program.

Visit lark.com/anthemBC and take the one-minute Prediabetes Risk Test to determine if you are at risk for prediabetes. If the test indicates that you have prediabetes or are likely to have prediabetes, you'll be given a link to download Lark from the App Store® or Google Play™. You can begin interacting with your digital Lark coach immediately.

This program can help you:

- Lose weight
- Eat healthier
- Increase activity
- Sleep better
- Manage stress

Anthem lark

Don't let prediabetes control your future. Let Lark show you how small changes now can lead to better health moving forward. Scan this QR code with your smartphone and take the one-minute quiz to determine your risk.

Livongo – Express Scripts

LIVONGO DIABETES MANAGEMENT PROGRAM

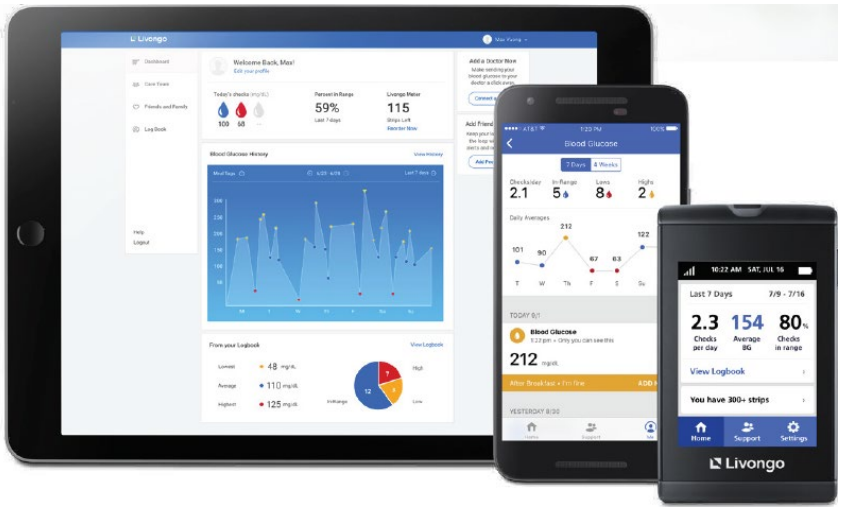
Livongo's design has proven to be successful in achieving behavioral changes that result in better management of diabetic conditions. With Livongo, covered individuals diagnosed with Diabetes can receive targeted support and guidance for better management of their condition.

Livongo enrollees will be given a free cellular connected glucose monitor for effortless real-time data collection, free test strips to ensure regular/timely testing, personalized health nudges to deliver calls when members are most receptive, and human-centered support 24/7 with live 1:1 coaching from credentialed clinicians.

Eligible individuals interested in participating can enroll online at welcome.livongo.com/PRISM or via telephone at (800) 945-4355 using registration code: **PRISM**

You'll get this and more when you sign up:

- Unlimited strips
- Connected glucose meter
- Personalized insights and more



Livongo®

Hinge Health

EXERCISE THERAPY PROGRAM

Hinge Health is an exercise therapy program designed to address chronic back, knee, hip, neck, shoulder, or other pain. It's convenient and fits your schedule? it can be done anywhere, at any time.

WHAT DOES THE PROGRAM INCLUDE?

1. Personalized exercise therapy to improve strength and mobility in short, 15-minute sessions

2. Personal care team to provide care, motivation, and support virtually

3. Interactive education to teach you how to manage your specific condition, treatment options, and more

WHO IS IN MY CARE TEAM?

Your care team includes a personal health coach and physical therapist. You will work with the same care team throughout your entire experience.

HOW MUCH DOES THE PROGRAM COST?

It’s free for eligible participants. This includes the Hinge Health kit, which you can keep forever.

WHO IS ELIGIBLE?

Members, pre-65 retirees, and dependents 18+ enrolled in a PRISM medical plan through Anthem are eligible (includes EPO and PPO).

HOW DO I APPLY?

Take a short online questionnaire following the link below, telling us about your pain. No referral or diagnosis needed from a doctor.

To learn more call (855) 902-2777, or apply at

HINGEHEALTH.COM/PRISM

Hinge Health

Prescription Drugs

Prescription drug coverage provides a benefit that is important to your overall health, whether you need a prescription for a short-term health issue like bronchitis or an ongoing condition like high blood pressure. Here are the prescription drug benefits that are included with our medical plans.

EXPRESS SCRIPTS®	Express Scripts EPO Plan	Express Scripts PPO Plan	
	In-Network	In-Network	Out-Of-Network
Annual Out-of-Pocket Limit	$1,000 per individual	$1,000 per individual	Not applicable
Pharmacy			
Generic	$10 copay	$10 copay	$10 copay
Preferred Brand	$20 copay	$20 copay	$20 copay
Non-preferred Brand	$30 copay	$30 copay	$30 copay
Supply Limit	30 days	30 days	30 days
Mail Order			
Generic	$20 copay	$20 copay	Not covered
Preferred Brand	$30 copay	$30 copay	Not covered
Non-preferred Brand	$45 copay	$45 copay	Not covered
Supply Limit	90 days	90 days	Not applicable

Prescription Drugs: Smart90 Program

GET THE FACTS ON YOUR MAINTENANCE MEDICATION PHARMACY NETWORK

As part of your prescription benefit, you have access to a money-saving feature for your maintenance medications (those drugs you take regularly for ongoing conditions). Through your plan, you must fill a 90-day supply of your maintenance medications at a preferred pharmacy – but you could **pay less** for each 90-day supply than you would pay for three 30-day supplies at a non-preferred retail pharmacy.[1]

THERE ARE TWO WAYS TO SAVE ON YOUR MAINTENANCE PRESCRIPTIONS

1. For savings and convenience, take advantage of home delivery from the Express Scripts Pharmacy. Get 90-day supplies of your medications delivered direct to you, safely and securely, with free standard shipping.[2]

   Log in at express-scripts.com or call the number listed on the back of your member ID card to learn how to get started with home delivery. Express Scripts can contact your doctor to have a new 90-day prescription sent right to you.

2. Or, you can transfer your maintenance prescriptions to a nearby CVS or Walgreens pharmacy. The pharmacist will contact your doctor to get a new 90-day prescription or will transfer your current 90-day prescriptions from the non-preferred pharmacy.

Your copayment for your 90-day supply will be the same whether you fill your prescriptions through Express Scripts home delivery or at a CVS or Walgreens pharmacy. [3]

[1] If the cost of a medication at a retail pharmacy is lower than your plan's retail copayment or coinsurance, you will not pay more than the retail pharmacy's cash price, regardless of the number of times you purchase the prescription. In some cases, this price may be less than either your standard retail or mail copayment or coinsurance.

[2] Cost of standard shipping is included as part of your prescription benefit.

[3] Price may vary slightly for coinsurance plans.

EXPRESS SCRIPTS MOBILE APP

Managing your medicine is easier when your app does it for you. The Express Scripts mobile app lets you easily and quickly find everything you need for your medicine. It's like having a knowledgeable pharmacist in your pocket.

You can find a preferred pharmacy, refill your prescriptions, check your order status, and even set up reminders to take your medication.

You also have instant access to your digital member ID card.

Prescription Drugs: Advantage Plus UM Package

Prior Authorization

MAKING SURE YOUR MEDICINE IS RIGHT FOR YOU

When you're prescribed certain medicines, your pharmacist may tell you it requires prior authorization. That means Express Scripts (ESI) needs more information to make sure the prescribed medicine will work well for you and your condition and that it's covered by your pharmacy benefit. Only your physician can provide this information and request a prior authorization for this medicine.

Drug Quantity Management

THE RIGHT MEDICINE IN THE RIGHT AMOUNT

When you're prescribed certain medicines that are a part of a drug quantity management (DQM) program, ESI makes sure you get it in the amount – or quantity – considered safe and effective by the U.S. Food & Drug Administration (FDA). So you get the right medicine in the right amounts for good health and the health of your family.

Step Therapy

THE MOST EFFECTIVE MEDICINE FOR YOUR HEALTH AND YOUR MONEY

Step therapy simply means making sure you get safe and proven-effective medicine for your condition – at the lowest possible cost to you and your plan sponsor. The next time your doctor writes you a prescription, or if your current medicine qualifies, ask if a first-line generic medicine is right for you. Often, generic medicines have the same chemical makeup as their brand-name counterparts, and the same effect in the body, so the only real difference is cost.

Is My Medication Covered?

Members can use the Express Scripts Open Enrollment portal to find out more about their current therapy, whether it falls under Prior Authorization/Drug Quantity Management/Step Therapy, and the member's cost.

Visit https://www.express-scripts.com/frontend/open-enrollment/tehamacounty to find out more!

Prescription Drugs: SaveOn SP

Specialty medications can cost a lot of money. That's why your plan offers a program called SaveOnSP, to lower your out-of-pocket costs to $0.

Participate in SaveOnSP and save.

Over 250 specialty medications are eligible for the SaveOnSP program.[1] If you're filling an eligible medication, a representative from SaveOnSP will contact you to discuss the program.

You'll pay $0 for your medication when you participate in SaveOnSP. If you choose not to participate, you'll pay a higher copay when you fill your medication.

Conditions covered by SaveOnSP include, but are not limited to:

- Hepatitis C
- Multiple Sclerosis
- Psoriasis
- Inflammatory Bowel Disease
- Rheumatoid Arthritis
- Cancer

Here's an example of how it works.[2]

John's taking a specialty medication that's eligible for the SaveOnSP program. His copay is currently $70.

- **When he participates in SaveOnSP, he won't pay anything ($0) out-of-pocket.** He will work with SaveonSP to enroll with the applicable manufacturer copay assistance program.
- **If he decides not to participate in SaveOnSP, he can continue to pay his $70 copay.**

If John decides not to participate, his copay will no longer count toward his deductible or out-of-pocket maximum.

1. The drug classes, medications and associated copays included in this program are subject to change. Check your plan materials to see which medications are eligible for the SaveOnSP program.
2. For illustrative purposes only. Plans may vary.

Vision

Routine vision exams can not only correct vision, but also detect more serious health conditions. We offer you a vision plan through Vision Service Plan.

	VSP Vision Plan PRISM	
	In-Network	**Out-Of-Network**
Examination		
Benefit	$10 copay	Up to $45
Frequency	1 x every 12 months from last date of service	In-network limitations apply
Materials	$20 copay	See schedule below
Eyeglass Lenses		
Single Vision Lens	Plan pays 100% of basic lens	Up to $30
Bifocal Lens	Plan pays 100% of basic lens	Up to $50
Trifocal Lens	Plan pays 100% of basic lens	Up to $65
Frequency	1 x every 12 months from last date of service	In-network limitations apply
Frames		
Benefit	$150 Allowance (20% discount over allowance)	Up to $70
Frequency	1 x every 24 months from last date of service	In-network limitations apply
Contacts (Elective)		
Benefit	$130 Allowance (copay waived; instead of glasses)	Up to $105 (in-network limitations apply)
Frequency	1 x every 12 months from last date of service	In-network limitations apply

Dental

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.

DELTA DENTAL®	Delta Dental DPPO Plan PRISM	
	In-Network	Out-Of-Network
Calendar Year Deductible	$25 per individual $75 per family	$25 per individual $75 per family
Annual Plan Maximum	$1,700 per individual	$1,500 per individual
Waiting Period	12 months for major services	In-network limitations apply
Diagnostic and Preventive	Plan pays 100%	Plan pays 100%
Basic Services		
Fillings	Plan pays 80% after deductible	Plan pays 80% after deductible
Root Canals	Plan pays 80% after deductible	Plan pays 80% after deductible
Periodontics	Plan pays 80% after deductible	Plan pays 80% after deductible
Major Services	Plan pays 80% after deductible	Plan pays 80% after deductible
Orthodontic Services		
Orthodontia	Not covered	Not covered

Life Insurance

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 and pay for large expenses such as housing and education, as well as day-to-day living expenses.

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 company. Coverage is provided by Voya Financial.

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

VOLUNTARY LIFE

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is provided by Voya Financial.

Employee Voluntary Life Amount	Increments of $10,000 (minimum $20,000) up to Lesser of 5 x covered annual earnings or $500,000, Guaranteed Issue: $150,000
Spouse Voluntary Life Amount	Increments of $5,000 (minimum $10,000) up to $250,00 and not to exceed 50% of employee amount, Guaranteed Issue: $50,000
Child(ren) Voluntary Life Amount	$10,000, Guaranteed Issue: $10,000

Evidence of Insurability: 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.

Taxes: A life insurance benefit of $50,000 or more is a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck and W-2.

VOYA FINANCIAL

Other Programs

EMPLOYEE ASSISTANCE PROGRAM

There are times when everyone needs a little help or advice. The confidential Employee Assistance Program (EAP) through ACI Specialty Benefits Corporation can help you with things like stress, anxiety, depression, chemical dependency, relationship issues, legal issues, parenting questions, financial counseling, and dependent care resources. Best of all, it's free.

Help is available 24/7, 365 days a year by telephone at (800) 932-0034. Other resources are available online at acieap.com.

In-person counseling may also be available, depending on the type of help you need. The program allows you and your family/household members up to 3 per incident per year.

Additional benefits are available through your medical plan. Review your medical benefit summary for more information.

VALUE ADDED SERVICES AS A VOYA MEMBER

CONFIDENTIAL COUNSELING (ADMINISTERED BY COMPYSCH)

This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. It is staffed by Guidance Consultants who are highly trained masters and doctoral level clinicians who will listen to your concerns and quickly refer you to in-person counseling and other resources. **Contact ComPsych Guidance Resources for more information at (877) 533-2363.**

FUNERAL PLANNING AND CONCIERGE SERVICE (ADMINISTERED BY EVEREST)

The death of a family member is one of life's most stressful times. It requires grieving survivors to quickly make many decisions about funeral services, something most of us know little about. This service will assist with funeral planning and negotiation at time of need as well as pre-planning tools that can be used to research and document decisions and wishes. Everest is an independent service that works exclusively on behalf of their clients and is not associated with any funeral home or service provider. **If you would like additional information or assistance, contact an Everest Service Advisor at (800) 913-8318.**

TRAVEL ASSISTANCE (ADMINISTERED BY VOYA)

The Voya Travel Assistance program offers you enhanced security for your leisure and business trips.

You and your eligible dependents will have toll-free or collect call access to the Voya Travel Assistance customer service center. You can also access the services provided on the Voya Travel Assistance website, 24 hours a day, 365 days a year – from anywhere in the world! **Call (800) 859-2821 or (202) 296-8355 for more info!**

Other Programs, continued.

FLEXIBLE SPENDING ACCOUNT (FSA)

A Flexible Spending Account (FSA) lets you set aside money before it's taxed to pay for certain health or daycare expenses incurred during the plan year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. When making an election, you should be confident you will have qualified expenses to use the money—you must use the money in your account by the end of the plan year or the money is forfeited. You must re-enroll in this program each year. **Workterra administers this program.**

IMPORTANT CONSIDERATIONS

- Claims must be submitted no later than March 30, 2024.
- If you terminate employment during the plan year, expenses incurred only through your last day of employment qualify, and you have 60 days from your termination date to submit claims.
- Elections cannot be changed during the plan year, unless you have a qualifying life event (and the election change must be consistent with the event).
- Unused amounts will be forfeited at the end of the plan year, so it is very important that you plan carefully before making your election.
- FSA funds can be used for you, your spouse, and your tax dependents only.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children, unless they qualify as your tax dependents. (Important: questions about the tax status of your dependents should be addressed with your tax advisor.)
- Keep your receipts. In most cases, you'll need to provide proof that your expenses were considered eligible for IRS purposes.

HEALTH FSA ACCOUNT

This plan allows you to pay for eligible out-of-pocket medical, dental or vision expenses with pre-tax dollars. Eligible expenses include plan deductibles, copays, coinsurance amounts and other non-covered healthcare costs for you, your spouse, and your tax dependents. You may access your entire annual election from the first day of the plan year, and you can set aside up to $2,850 this year.

Refer to Publication 959 at www.irs.gov for details.

DEPENDENT CARE FSA

A Dependent Care FSA allows you to use pre-tax dollars to pay for eligible out-of-pocket daycare expenses such as those for dependent care centers, in-home childcare, and before or after school daycare so you and your spouse can work. Eligible expenses may include daycare care for your dependent children under age 13 or an adult dependent if they are incapable of self-care, are your tax dependent, and live with you. It is important to note that you can access money only after it is placed into your Dependent Care account.

All caregivers must have a tax ID or Social Security number. This information must be included on your federal tax return. If you use a Dependent Care FSA, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can elect up to $5,000 per year to the Dependent Care FSA. This limit is reduced in certain circumstances such as married employees filing separate returns ($2,500) or if your spouse’s earned income if less than $5,000 per year.

Refer to Publication 15b at www.irs.gov for details

Cost of Coverage

In general, you pay for health coverage before federal, state, and social security taxes are withheld, so you pay less in taxes. 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. Please contact the Personnel Office at (530) 527-4183 if you have questions about your premiums for 2023.

ALL FULL TIME TEHAMA COUNTY EMPLOYEES
JANUARY 1, 2023 MONTHLY PREMIUMS

Coverage	EPO	PPO
Health	$ 1,783.00	$ 2,208.00
Dental	$ 63.60	$ 63.60
Vision	$ 11.97	$ 11.97
Life ($30,000)	$ 5.58	$ 5.58
Total Premium	$ 1,864.65	$ 2,289.65
(Less County Contribution)	($1,661.72)	($1,661.72)
Employee Portion of full package	**$ 202.93***	**$ 627.93***
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

RETIREES UNDER AND OVER 65
JANUARY 1, 2023 MONTHLY PREMIUMS

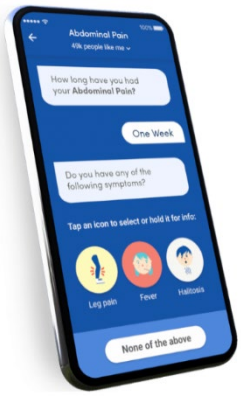
Coverage	EPO	PPO
Health		
Retiree only under 65	$1783.50	$2208.50
Retiree + Spouse both under age 65	$1783.50	$2208.50
Retiree + Spouse both under age 65 plus family	$1783.50	$2208.50
Retiree only, age 65 or older	$ 813.50	$1069.50
Retiree + Spouse, both age 65 or older	$1624.50	$2135.50
Retiree (both 65+) and Family	$2274.50	$2858.50
Retiree + Spouse, one over & one under age 65 (one w/Medicare, one w/o Medicare)	$1694.50	$2274.50
Retiree over 65 + family (contact WorkTerra)		
Dental	$ 63.60	$ 63.60
Vision	$ 11.97	$ 11.97
Life ($1,000 policy)	$ .20	$ .20
Life ($5,000 policy)	$ 1.00	$ 1.00

COBRA RATE
JANUARY 1, 2023 MONTHLY PREMIUMS

Coverage	EPO	PPO
Health	$1819.17	$2252.67
Dental	$ 64.87	$ 64.87
Vision	$ 12.21	$ 12.21
Total Package Premium	$1896.25*	$2329.75*

* Premiums reflect a 2% administration fee.

For Assistance



INTRODUCING SYDNEY – ANTHEM'S MOBILE APP!

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

You get one-click access to benefits info, your member ID card and wellness resources. That means you can quickly find what you need.

The more you use it, the more Sydney can help you stay healthy and save money. And Sydney's interactive chat feature can answer your questions in real time.

Find care and check costs, view claims, see your benefits, view your ID card and more!

DELTA DENTAL MOBILE APP

Logging in to View Benefits

Delta Dental subscribers can log in using the username and password they use to log in to our website. If you haven't registered, there is a link on the home screen to register for an account. If you've forgotten your username or password, you can also retrieve these via Delta Dental Mobile.

Securely Access Your Benefits

You must enter your user name and password each time you access the secure portion of the app. No personal health information is ever stored on your device. For more details on security, our Privacy Policy can be viewed via a link on the Login page of the app.

VSP AT YOUR FINGERTIPS

- Find a doctor by name or location, and get directions to your appointment.
- Access your Member Vision Card and personal benefit information.
- View Exclusive Member Extras, like rebates, special offers, and promotions.
- Get eye care information on a variety of topics to maintain optimal eye health.

Plan Contacts

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

Plan Type	Provider	Phone Number	Website	Policy/Group #
Medical	Anthem	(800) 967-3015	www.anthem.com/ca/prism	175075
Prescription Drugs	Express Scripts	(877) 554-3091	www.express-scripts.com	175075
Dental	Delta Dental	(800) 765-6003	www.deltadentalins.com	2576
Vision	VSP	(800) 877-7195	www.vsp.com	30016659
Life and AD&D	VOYA	(800) 955-7736	www.voya.com	31640-7
Employee Assistance Program	ACI Specialty Benefits	(800) 932-0034	www.acispecialtybenefits.com	County of Tehama
FSA	Workterra	(888) 327-2770	www.workterra.com	County of Tehama

Key Terms

Health insurance seems to have its own language. You will get more out of your plans if understand the most common terms, explained below in plain English.

MEDICAL

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.

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.

COINSURANCE - After you meet the deductible amount, you and your health plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 70% coinsurance, you are responsible for paying your coinsurance share, 30% of the cost.

COPAY - A set fee you pay whenever you use a particular healthcare service, for example, when you see your doctor or fill a prescription. After you pay the copay amount, your health plan pays the rest of the bill for that service.

IN-NETWORK / OUT-OF-NETWORK - Network providers (doctors, hospitals, labs, etc.) are contracted with your health plan and have agreed to charge lower fees to plan members, as negotiated in their contract with the health plan. Services from out-of-network providers can cost you more because the providers are under no obligation to limit their maximum fees. With some plans, such as HMOs and EPOs, services from out-of-network providers are not covered at all.

OUT-OF-POCKET MAXIMUM - The most you would pay from your own money for covered healthcare expenses in one year. Once you reach your plan's out-of-pocket maximum dollar amount (by paying your deductible, coinsurance and copays), the plan pays for all eligible expenses for the rest of the plan year.

PRESCRIPTION DRUG

BRAND NAME - A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. You generally pay a higher copay for brand name drugs.

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. You generally pay a lower copay for generic drugs.

PREFERRED DRUG - Each health plan has a list of prescription medicines that are preferred 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.

DENTAL

BASIC SERVICES - Dental services such as fillings, routine extractions and some oral surgery procedures.

DIAGNOSTIC AND PREVENTIVE SERVICES - Generally include routine cleanings, oral exams, x-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to two times a year.

MAJOR SERVICES - Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

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 qualifying event or qualify for a "special enrollment". If you qualify for a mid-year benefit change, you will be required to submit proof of qualifying event giving rise to the change.

QUALIFYING EVENTS 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 that affects eligibility for benefits.
- **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 change you make must be consistent with the change in status, AND
- You must make the change within 31 days of the date the event occurs (event + 30 days).

Important Plan Notices and Documents

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:	9/1/2022
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. 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's 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 the 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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program 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://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html

Phone: 1-877-357-3268

GEORGIA – Medicaid

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

Healthy Indiana Plan for low-income adults 19-64 | Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid | Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

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

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 617-886-8102

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

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

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084 | 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. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
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: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid 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, 2022, 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 is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to 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.

OMB Control Number 1210-0137 (expires 1/31/2023)

NOTICE OF CERTAIN DEADLINE EXTENSIONS

End of Relief Period Extending Certain Deadlines in Response to the COVID-19 Crisis will Depend on the Date an Individual Action Would Have been Required with some Deadlines resuming Feb. 28, 2021

On April 28, 2020 Multi-Agency guidance extended certain deadlines that apply to group health plans that fall within the COVID-19 outbreak period beginning **March 1, 2020**. Those deadlines included and were limited to the following:

- The 30-day period to request special enrollment under HIPAA (or 60-day period as applicable to CHIP enrollment requests);
    - employees, spouses, and new dependents are allowed to enroll upon marriage, birth, adoption, or placement for adoption;
    - employees and dependents are allowed to enroll if they had declined coverage due to other health coverage and then lose eligibility or lose all employer contributions towards active coverage;
    - employees and their dependents are allowed to enroll upon loss of coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs;
- The 60-day election period for COBRA continuation coverage;
- The deadline for making COBRA premium payments;
- The 60-day deadline for individuals to notify a plan of a COBRA qualifying event or determination of disability;

The period that these deadlines can be tolled is limited to one year. On Feb. 28, 2021, one year from March 1, 2020, some of the above timelines will no longer be tolled.

Individual timeframes listed above that are subject to deadline relief will have the applicable deadlines disregarded only until the earlier of: (a) 1 year from the date they were first eligible for relief, or (b) 60 days after the announced end of the National Emergency (the end of the Outbreak Period). On those individualized applicable dates, the timeframes for employees/participants with periods that were previously tolled will resume.

Examples and Explanations:

> If a qualified beneficiary would have been required to make a COBRA election by March 1, 2020, the individual can wait until February 28, 2021, which is the earlier of 1 year from March 1, 2020 or the end of the Outbreak Period. Because the individual had 60 days to elect before the start of the Outbreak he or she would need to make an election by February 28, 2021.
>
> If a qualified beneficiary would have been required to make a COBRA election by March 1, 2021, the Notice delays that election requirement until the earlier of 1 year from that date (March 1, 2022) or the end of the Outbreak Period, with the possibility of an additional 60-day extension.
>
> If an individual experienced the birth of a child in February 2021 and the National Emergency was declared over July 1, 2021 **(hypothetically)**, the employee would have 60 days from the end of the National Emergency plus 30 days under HIPAA to give notice of the birth to request enrollment from the plan, September 29, 2021.

Again, if you have any questions regarding these changes to the Plan or your specific circumstances, please contact the Personnel Office during normal business hours at 727 Oak Street, Red Bluff, CA 96080, telephone number (530) 527-4183 or visit our website at www.co.tehama.ca.us/government/departments/personnel/.

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 9.12% in 2023 of your modified adjusted household income.

Rev. 9/26/2022