

COUNTY OF SONOMA

Human Resources Benefits Unit • (707) 565-2900 • hr.benefits@sonomacounty.gov

2026-2027 EMPLOYEE BENEFITS GUIDE



Opportunity. Diversity. Service.



COUNTY OF SONOMA
HUMAN RESOURCES DEPARTMENT

Welcome...

The County of Sonoma offers a comprehensive health and welfare benefits program designed to meet the needs of our diverse workforce.

This Benefits Guide is designed to help you make informed decisions regarding your health benefit elections as a newly eligible employee, during the Annual Enrollment period, and for any potential mid-year changes you may experience throughout the year.

Within this guide, you'll find overviews for each of the health benefit providers, medical plan comparison charts, plan premiums and information to help you determine if you are eligible for a mid-year plan change and when those changes need to be made.

We encourage you to use this Benefits Guide as a reference throughout the plan year. If you have questions, contact the Human Resources Benefits Unit or the plan providers directly. Plan phone numbers and web sites are listed on page 53 of this Benefits Guide.

RETIRING IN THE NEXT YEAR?

Attend a "Ready To Retire" training to learn more about eligibility and benefits offered to retirees. To find and enroll in a class visit <https://sonomacounty.sabacloud.com>. You can receive an eligibility pre-determination by sending an email to hr.benefits@sonomacounty.gov. Include your name(s), start date, potential retirement date, and any gaps in service. For more information regarding our retiree benefits visit <https://sonomacounty.gov/benefits>.

This Benefits Guide is intended as an overview of your medical benefits including eligibility, plan options, rates, how to enroll, and other important information. More detailed information is available in the official plan documents. For information about your other County benefits, visit <https://sonomacounty.gov/benefits>.

Your benefit eligibility is determined by the terms of your applicable Memorandum of Understanding (MOU), Employee Contract, or Salary Resolution.

This Benefits Guide is not a promise of continued or future benefits. The information provided is current and applicable as of the printing of this guide. In the case of conflict between the information presented in this Benefits Guide and the official plan document, the plan document determines the coverage.

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ANNUAL ENROLLMENT

Annual Enrollment is **March 23rd - April 10th, 2026**. Annual Enrollment is your opportunity to add, drop, or waive coverage for you or your dependents, and to ensure that our records accurately reflect your benefit elections. You can enroll and make changes to your plans online in Employee Self Service (ESS). For more information regarding Annual Enrollment, visit our website at <https://sonomacounty.gov/annual-enrollment>.

During Annual Enrollment, you may:

- Enroll in coverage
- Change your medical plan
- Add/Drop/Waive dependents from your coverage
- Decline medical coverage
- Waive medical coverage (if enrolled in other Group Coverage or Covered CA)

Information to prepare and update:

Dependent data

- Names
- Birthdates
- Social Security Numbers (SSN) or Tax Identification Numbers (TIN)
- Dependent Verification Documentation

Beneficiary designations

There are no set deadlines for updating your beneficiary designations, but the Annual Enrollment Period is a great time for you to update them to ensure they are current. It is recommended that you complete a new beneficiary designation form every 3 years.

Personal information:

If you've moved or changed your contact information, be sure to enter the change in ESS. If you changed your name, notify your Payroll Clerk. It's important to keep your personal information up-to-date at all times.

Ready to enroll or make changes?

To update dependents, make plan changes, and enroll or waive coverage for you and your family, login to ESS at <https://ess.sonomacounty.ca.gov>.

If an eligible dependent is not listed in ESS for each of your benefit plans (i.e. medical, dental, and vision), that dependent will not be covered and will not be able to access benefits when seeking services. Dependents who are no longer eligible must be removed from coverage and failure to do so in a timely manner may result in your liability to repay the health insurance provider if any benefits are paid to or on behalf of an ineligible person.

BENEFIT ELIGIBILITY

Benefits must be offered to you through a Memorandum of Understanding (MOU), Employee Contract, or Salary Resolution.

To be eligible for the medical, dental, and vision benefits listed in this Benefits Guide, you must be an employee in a permanently allocated position scheduled to work a minimum of 32 hours per pay period (.40 FTE) and have received pay for at least one half of your scheduled hours (or be on an approved leave pursuant to applicable law or MOU, Employee Contract, or Salary Resolution provision).

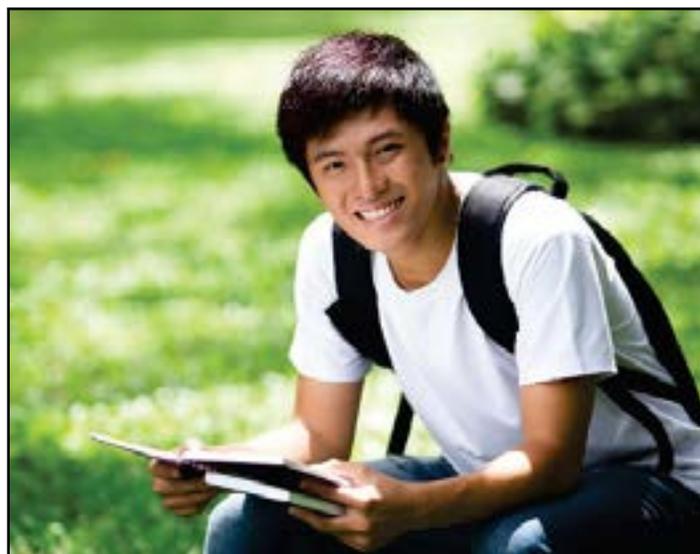
New to the County of Sonoma? Visit our New Employee Resource Page at <https://sonomacounty.gov/new-employee-resources>

PART TIME EMPLOYEES

Part time employees in allocated positions of 32 hours or more per pay period (.40 FTE minimum) are eligible to participate in the County's medical, dental, and vision plans. The County contribution is pro-rated for eligible part-time employees and based on the number of qualifying hours compared to a full-time employee. Qualifying hours include hours worked and qualified leave hours. Contact your Payroll Clerk if you have questions regarding your eligibility for a pro-rated County contribution.

Employees in one of the following bargaining units who are in .75 FTE positions (60 hours or more bi-weekly) are eligible to receive the full County contribution for medical, dental, and vision plans.

- SAL RES BOS (49)
- SAL RES CNF (51)
- SAL RES DH (52)
- SAL RES MGMT (50)
- SCLEMA (44)
- SCPA (45)
- SCDPDAA (60)
- SCPDIA (55)
- Unrepresented (00)

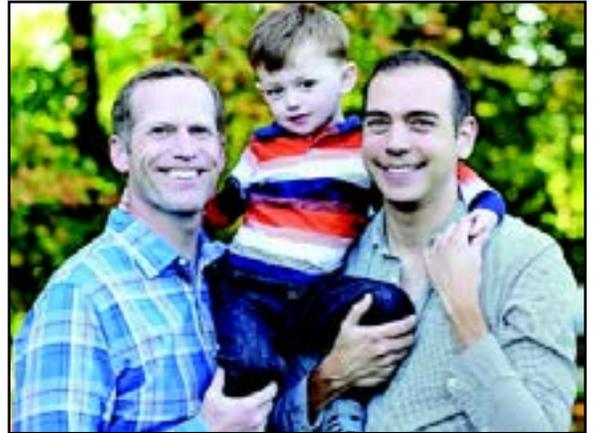


DEPENDENT ELIGIBILITY

If you are eligible to participate in County-sponsored medical, dental and vision plans, your eligible dependents may also participate. Your eligible dependents include:

- Your lawfully married spouse
- Your California state registered domestic partner*
- Your or your spouse/domestic partner's dependents including son, daughter, step-son, step-daughter, legally adopted child, a child placed with you for adoption, eligible foster child, or child for whom you are the legally appointed guardian
- Child under a Qualified Medical Child Support Order (QMCSO)

Dependent coverage will end the last day of the month in which the dependent turns age 26. See your Memorandum of Understanding or Salary Resolution to verify dependent eligibility. An exception is available for an unmarried dependent child over the plan's age limit, who is chiefly dependent upon the subscriber for support, and is incapable of supporting one's self due to mental or physical disability incurred prior to reaching the limiting age.



*A County Domestic Partnership Affidavit is acceptable for SEIU members. All other bargaining units must have a California State Registered Domestic Partnership.

SOCIAL SECURITY NUMBERS ARE REQUIRED

You are required to provide a Social Security number (SSN) or a Federal Tax Identification number (TIN) for your dependent(s) when you enroll them in a County sponsored medical plan. The County needs this information to comply with IRS reporting and the Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173). If a dependent does not yet have a social security number, you can go to the Social Security Administrations website to complete a form to request a SSN: <https://www.ssa.gov/forms/ss-5.pdf>. If you have not yet provided the social security number (or other TIN) for each of your dependents that you have enrolled in the health plan, please provide the Social Security number to the Human Resources Benefits Unit.

DEPENDENT VERIFICATION

All dependents currently enrolled and newly enrolling in County-sponsored medical plans will be required to show proof of dependency. Please use the chart below to determine what documentation to provide to the HR Benefits Unit for each dependent you are enrolling in medical coverage.

DEPENDENT	AGE	DOCUMENTS REQUIRED
Spouse	Not Applicable	Certified Marriage Certificate
Domestic Partner	Not Applicable	SEIU: County Affidavit or Declaration of Domestic Partnership filed with the California Secretary of State ALL OTHERS/SAL RES: Declaration of Domestic Partnership filed with the California Secretary of State
Natural Children	Under Age 26	Certified Birth Certificate
Step Child(ren)	Under Age 26	Certified Marriage and Birth Certificates showing Spouse as Parent
Children Legally Adopted/Wards	Under Age 26	Court documentation (Must include presiding Judge Signature & Court Seal)
Children of Domestic Partners	Under Age 26	SEIU: County Affidavit or Declaration of Partnership filed with the California Secretary of State -and-Birth Certificate showing Domestic Partner as Parent ALL OTHERS/SAL RES: Declaration of Domestic Partnership filed with the California Secretary of State-and-Birth Certificate showing parent as Domestic Partner

DUAL COVERAGE NOT ALLOWED

An eligible employee/retiree and their eligible dependent(s) may be enrolled in a County sponsored medical plan, but must enroll either as a subscriber in a County sponsored medical plan or, as the dependent spouse/domestic partner of another eligible County employee/retiree, but not both. If an employee/retiree is also eligible to cover their dependent child(ren), each child will be allowed to enroll as a dependent on only one employee's or retiree's plan (i.e., a retiree and their dependents cannot be covered by more than one County sponsored health plan).

COUNTY CONTRIBUTION FOR MEDICAL COVERAGE



You and the County share in the costs of your medical plan benefits. The plans are funded through the County's and your contributions toward medical plan premiums; costs are incurred as plan participants seek medical care and claims are paid for that care. As is the case with most health plans, the total medical premium costs increase from year-to-year. In addition, because employees pay the difference between the total premium cost and the County's contribution, premium increases have a direct effect on your contribution cost.

The relationship between premiums and a plan participant's use of the plans is important to understand – because plan utilization is a key driver of the premium rates. This means that your decisions as you use your plan benefits can make a difference.

Use your benefits wisely;

- Be aware of the costs of the services you select
- Use in-network providers when possible
- Choose generic drugs when possible
- Commit to making healthy lifestyle choices to avoid chronic health conditions

Statistics have shown that 50% of medical costs are the result of our own behavioral choices, such as whether we choose to exercise, maintain a healthy weight, use tobacco products, etc. Making the choice to live healthier is one way you can help keep future costs down. Actively participate in the County's wellness program. Let your doctor know that cost is important to you. Talk to your doctor about the cost of care to see if there are more affordable ways to achieve the desired outcome. Do not avoid necessary treatment due to cost. Preventive treatment is shown to save costs in the long run by identifying issues early.

PRE-TAX/POST-TAX INSURANCE BENEFITS

County employees generally pay for their health benefits on a pre-tax basis. When you enroll your dependent(s) in a County medical or dental plan, you must indicate whether each is an IRS-Qualified or Non-Qualified tax dependent. If a County employee's dependent is considered an Internal Revenue Service (IRS) qualified dependent, the County contribution for the dependent's benefit is also tax free and the employee's share of cost is paid on a pre-tax basis. If a County employee enrolls a non-qualified dependent, the employee and any qualified dependents will be paid on a pre-tax basis while non-qualified dependent benefits will be paid on a post-tax basis.

IS MY DEPENDENT IRS-QUALIFIED?

In accordance with the law, the County's benefits coverage can be provided on a tax-free basis to any eligible spouse, or eligible child of the employee until the end of the month in which the child becomes ineligible for County sponsored health plans. If your eligible dependent is your own natural child, your step child, adopted child, child lawfully placed for adoption, or eligible foster child, you may indicate each as IRS Qualified regardless of the child's marital or student status or whether or not the child is claimed as a dependent on your taxes.

Covered dependents who may not be eligible for tax-free health care (and require an employee to indicate that a dependent is IRS Non-Qualified) applies to your domestic partner and any children of your domestic partner (unless you have adopted the children) or dependents for whom you are the legal guardian, as these individuals are not always recognized as federal tax dependents, and therefore are IRS non-qualified, unless they meet the definition of Qualifying Child or Qualifying Relative as defined by the IRS.

To be an IRS Qualified Dependent a dependent must fall into one of two categories defined by the IRS. They must be either a Qualifying Child, or a Qualifying Relative. There are specific tests that must be met under each of these categories for them to be considered IRS Qualified Dependents. Refer to the Overview of the Rules for Claiming an Exemption for a Dependent in IRS Publication 17 at <https://www.irs.gov/pub/irs-pdf/p17.pdf>.

Note: The above information is about taxation only. You are strongly encouraged to check with a tax professional or the IRS at <http://www.irs.gov/> to clarify any questions you may have about your dependents' tax status.

KEY ITEMS TO CONSIDER IN CHOOSING A MEDICAL PLAN

- Compare benefit coverage levels and premium costs carefully to see which option best fits your needs.
- Review the “Service Areas” of the medical plan you are interested in to ensure you are eligible for enrollment based on where you live.
- Dependents must be enrolled in the same plan as yourself.
- Premium and out-of-pocket costs vary significantly between the HMO, Hospital Services and Deductible First plans. You and the County share the cost of the premiums. Your share of the premium cost will be processed through payroll deductions. Out-of-pocket costs, such as deductibles, copays, and coinsurance, are your responsibility and may be incurred at the time of service.
- In the CHP PPO, you may obtain services from either In-Network (preferred) or Out-of-Network (non-preferred) providers, but you will pay less out of your own pocket when you use an In-Network provider.
- In the CHP EPO, (Exclusive Provider Organization) all services must be obtained from within the EPO network; there are no Out-of-Network benefits, except in an emergency or if you have an authorized referral from a network provider.

SERVICE AREA REQUIREMENTS

The provider service areas are determined by zip code. Each provider has their own eligible service areas.

Kaiser Permanente

Employees must live or work in the service area, and their dependents can be covered if the employee is eligible. If you are unsure if you are in Kaiser’s service area, contact HR Benefits at hr.benefits@sonomacounty.gov.

Sutter Health Plan

Employees must live or work in the service area, and their dependents can be covered if the employee is eligible. For location information go to <https://sonomacounty.gov/sutter-health-plan> and click on the link in the service area section of the page.

Western Health Advantage

Employees can live or work in the service area. All other enrolled dependents must live in the service area. For location information visit <https://www.westernhealth.com/service-area-maps/>.

MEDICAL BENEFITS

The County of Sonoma cares about your health and well-being and is pleased to offer you a choice of medical plan options. You are eligible to choose from the following medical plans:

County Health Plan - **Closed to new enrollees**

- EPO (Exclusive Provider Organization)
- PPO (Preferred Provider Organization)

Kaiser Permanente

- Traditional HMO
- Hospital Services DHMO
- Deductible First HDHP

Sutter Health Plan

- Traditional HMO
- Hospital Services DHMO
- Deductible First HDHP

Western Health Advantage

- Traditional HMO
- Hospital Services DHMO
- Deductible First HDHP



When you enroll in a medical plan, you will also decide if you want to enroll your eligible dependents in coverage. You can choose one of three coverage levels, as follows:

- Employee
- Employee + 1
- Employee + 2 or more

Your eligible dependents must be enrolled in the same medical plan you have elected for yourself.

SUMMARY OF BENEFITS AND COVERAGE

You may view the Summary of Benefits and Coverage (SBC) information for each of the County's medical plans online at:

<https://sonomacounty.gov/benefit-forms-plan-documents-and-important-information>.

2026-2027 MEDICAL PLAN PREMIUM CHART

SEMI-MONTHLY RATES FOR ALL BARGAINING UNITS

County Health Plan EPO and PPO - CLOSED TO NEW ENROLLEES			
County Health Plan EPO	Employee Contribution	County Contribution	Total Premium Cost
Employee	\$98.24	\$516.00	\$614.24
Employee + 1	\$167.89	\$1,032.00	\$1,199.89
Employee + 2 or more	\$215.16	\$1,458.50	\$1,673.66
County Health Plan PPO	Employee Contribution	County Contribution	Total Premium Cost
Employee	\$228.21	\$516.00	\$744.21
Employee + 1	\$430.89	\$1,032.00	\$1,462.89
Employee + 2 or more	\$585.81	\$1,458.50	\$2,044.31

Traditional HMO			
Kaiser Permanente Traditional HMO	Employee Contribution	County Contribution	Total Premium Cost
Employee	\$124.67	\$516.00	\$640.67
Employee + 1	\$249.34	\$1,032.00	\$1,281.34
Employee + 2 or more	\$354.58	\$1,458.50	\$1,813.08
Sutter Health Plan Traditional HMO	Employee Contribution	County Contribution	Total Premium Cost
Employee	\$0.00	\$505.15	\$505.15
Employee + 1	\$0.00	\$1,010.30	\$1,010.30
Employee + 2 or more	\$0.00	\$1,429.65	\$1,429.65
Western Health Advantage Traditional HMO	Employee Contribution	County Contribution	Total Premium Cost
Employee	\$0.00	\$447.22	\$447.22
Employee + 1	\$0.00	\$894.44	\$894.44
Employee + 2 or more	\$0.00	\$1,265.65	\$1,265.65

County contributions listed in this guide are current as of February 15, 2026. County contributions are determined by an MOU, Salary Resolution, or Employee Contract. Changes to the County contributions made on or after February 16, 2026 can be found on the County of Sonoma website at:

<https://sonomacounty.gov/2026-2027-employee-semi-monthly-medical-premiums>.

2026-2027 MEDICAL PLAN PREMIUM CHART

SEMI-MONTHLY RATES FOR ALL BARGAINING UNITS

Hospital Services			
Kaiser Permanente Hospital Services	Employee Contribution	County Contribution	Total Premium Cost
Employee	\$0.00	\$508.58	\$508.58
Employee + 1	\$0.00	\$1,017.16	\$1,017.16
Employee + 2 or more	\$0.00	\$1,439.28	\$1,439.28
Sutter Health Plan Hospital Services	Employee Contribution	County Contribution	Total Premium Cost
Employee	\$0.00	\$432.75	\$432.75
Employee + 1	\$0.00	\$865.55	\$865.55
Employee + 2 or more	\$0.00	\$1,224.80	\$1,224.80
Western Health Advantage Hospital Services	Employee Contribution	County Contribution	Total Premium Cost
Employee	\$0.00	\$370.72	\$370.72
Employee + 1	\$0.00	\$741.48	\$741.48
Employee + 2 or more	\$0.00	\$1,049.21	\$1,049.21

Deductible First			
Kaiser Permanente Deductible First	Employee Contribution	County Contribution	Total Premium Cost
Employee	\$0.00	\$463.81	\$463.81
Employee + 1	\$0.00	\$927.62	\$927.62
Employee + 2 or more	\$0.00	\$1,312.57	\$1,312.57
Sutter Health Plan Deductible First	Employee Contribution	County Contribution	Total Premium Cost
Employee	\$0.00	\$407.35	\$407.35
Employee + 1	\$0.00	\$814.70	\$814.70
Employee + 2 or more	\$0.00	\$1,152.80	\$1,152.80
Western Health Advantage Deductible First	Employee Contribution	County Contribution	Total Premium Cost
Employee	\$0.00	\$336.21	\$336.21
Employee + 1	\$0.00	\$672.44	\$672.44
Employee + 2 or more	\$0.00	\$951.51	\$951.51

PLANS OFFERED BY: COUNTY HEALTH PLAN

EXCLUSIVE PROVIDER ORGANIZATION (EPO)

The County Health Plan EPO is an exclusive provider organization (EPO). The EPO is a network of Hospitals, Physicians, medical laboratories, and other Health Care Providers who are located within a Service Area and who have agreed to provide Medically Necessary services and supplies for favorable negotiated discount fees applicable only to EPO Plan participants.

- Under the EPO Plan there is coverage ONLY when you use an EPO provider.
- All care in the County Health Plan EPO must be obtained within the plan network, except if you have an authorized referral from a network provider or if you have an emergency.

The EPO Plan offers you affordable out-of-pocket costs, with access to the doctors and hospitals you trust. You are free to visit any doctor or hospital in the EPO network when you pay an affordable copay or deductible, without the hassle of filling out claim forms. Covered services must be provided by EPO network providers. Most doctor and specialist office visits are available at a \$50 copay and most in-network preventive services, such as well baby/child visits, immunizations, routine physicals, mammograms, and routine preventive screenings are covered at no cost. Other in-network services are covered at 80% after the deductible (\$500 per individual or \$1,500 per family) is met.

PREFERRED PROVIDER ORGANIZATION (PPO)

The County Health Plan PPO is a preferred provider organization (PPO). A PPO is a medical plan that offers you a choice between an in-network group of providers who offer their services at discounted rates and out-of-network providers without discounted rates. Under a PPO plan, you may choose the level of benefits you receive based on the providers you use when you receive care. Most in-network doctor and specialist office visits are available at a \$20 copay and most in-network preventive services, such as well baby/child visits, immunizations, routine physicals, mammograms, and routine preventive screenings are covered at no cost. Other in-network services are covered at 90% after the deductible (\$300 per individual or \$900 per family) is met.

Employees who have an HRA (Health Reimbursement Arrangement), or an FSA (Flexible Spending Account), may submit medical, dental and vision out-of-pocket expenses, including copays and coinsurance for reimbursement.

PLANS OFFERED BY: KAISER PERMANENTE, SUTTER HEALTH PLAN AND WESTERN HEALTH ADVANTAGE

TRADITIONAL HMO

The Traditional HMO plans have a higher monthly premium with no deductible, low copays, and a lower out of pocket annual maximum, making your total annual expenses more predictable. Hospitalization, radiology, lab tests and most preventive services are also covered at no cost. Generally, specialist services require a referral from your primary care physician (PCP) and you must use the provider's network unless you have an out-of-area urgent or emergency situation or an approved referral.

HOSPITAL SERVICES DHMO

The Hospital Services DHMO plans offer a lower monthly premium with deductibles only on hospital related services, including emergency room visits, inpatient stays, and outpatient surgery. You pay the full cost of these services up to the deductible then a 20% coinsurance until you reach your out-of-pocket maximum. The out-of-pocket maximum includes the calendar year deductible, copays, and coinsurance. Physician and specialist visits, radiology, lab tests, and prescriptions have a flat copay, without having to meet the deductible. Preventative services are covered at no cost.

DEDUCTIBLE FIRST HDHP

The Deductible First HDHP plans offer the lowest monthly premium and requires a member to meet the calendar year deductible FIRST before ANY plan benefits will be paid, except covered preventative services. Members will pay 100% of the doctor office visits, radiology services, lab tests, prescriptions, hospitalizations, etc., until the calendar year deductible is met. Once the deductible is met, covered medical, hospital, and prescription benefits will be provided for a copay or coinsurance amount. The calendar year out-of-pocket maximum includes calendar year deductibles, copays, and coinsurance.

Take Note: If you (the employee) elect to enroll in the Deductible First HDHP, which qualifies as a HSA qualified high deductible health plan, and you have a Flexible Spending Account (FSA) and/or a Health Reimbursement Arrangement (HRA), be advised that under IRS rules you are NOT allowed to contribute to a Health Savings Account (HSA). Because FSA and HRA accounts can be used to reimburse your out-of-pocket medical expenses, the IRS does not allow you to also contribute to a HSA at the same time, as it is considered prohibited health coverage. While the County does not offer an HSA, this rule applies to all enrolled dependents in this plan. Dependents will not be able to contribute to an HSA through their employer if enrolled in a Deductible First HDHP plan.

COUNTY HEALTH PLAN (CHP)

CLOSED TO NEW ENROLLEES

The County Health Plan will be closed to new enrollees beginning with the June 1, 2024 plan year. Participants enrolled prior to June 1, 2024 will be grandfathered into the plan.

The EPO and PPO medical plan options are self funded, meaning the contributions from the County of Sonoma and eligible employees and retirees are used to pay plan benefits, including services provided to the members and claims administration. Anthem Blue Cross is the network provider and medical plan claims administrator for both the EPO and PPO plans. Plan members have access to more than 60,800 doctors and specialists that make up a strong local California network. Anthem Blue Cross has contracted with more than 90% of hospitals in California, including 400 acute care hospitals. If you reside within California, services are provided through the Prudent Buyer Plan network and if you reside outside of California, services are provided through BlueCard network. More than 96% of hospitals and more than 91% of physicians across the country contract with Anthem Blue Cross through the BlueCard® program. To find a network provider, visit <https://www.anthem.com/find-care/> or call (877) 800-7339.



RXBENEFITS

Prescriptions will be filled with a generic drug when available. If a generic drug is not available, the brand name drug will be filled and you will pay the brand name copay. If a generic drug is available but a brand name drug is medically necessary, as prescribed by your doctor, your doctor must request an exception to the plans' mandatory generic policy through RxBenefits prior to getting the prescription filled. If the exception is approved, you will be charged the brand name copay. If the exception is not approved or you choose the brand-name drug when a generic equivalent is available, you will be responsible for the brand name copay plus the difference between the brand name and generic cost. If you are taking a maintenance drug, it can be filled at any retail pharmacy twice. After the second fill, it must be filled at a RxBenefits pharmacy or by mail order through RxBenefits. Direct all prescription benefit appeals to RxBenefits Customer Service (800) 334-8134.

LIVE HEALTH ONLINE

When you're not feeling well you can get the support you need easily using LiveHealth Online. Whether you have a cold, you're feeling anxious or need help managing your medication, doctors and mental health professionals are right there, ready to help you feel your best. Using LiveHealth Online you can have a video visit with a board-certified doctor, psychiatrist or licensed therapist from your smartphone, tablet or computer from home or anywhere.

See a board-certified doctor 24/7, a licensed therapist in four days or less, or a board-certified psychiatrist within two weeks.

HEALTH CARE DESIGNED FOR THE COUNTY OF SONOMA WORKFORCE

Kaiser Permanente is committed to delivering high quality, convenient, and coordinated care for County of Sonoma employees and their families. As one of California’s most trusted integrated health care providers, Kaiser Permanente brings together physicians, specialists, pharmacies, labs, and hospitals—connected through a single electronic medical record—to support your total health.



EASY ACCESS TO CARE

With Kaiser Permanente, it’s simple to get the care you need when you need it. Members have access to:

- Primary care, urgent care, and emergency services
- Labor and delivery services
- A broad network of specialty care
- Multiple facilities in Sonoma County and Marin County
- Access to Kaiser Permanente facilities across California

Whether you’re at home, at work, or traveling within the state, you can count on a wide range of convenient locations and coordinated services.

PERSONALIZED, CONNECTED CARE

Every Kaiser Permanente doctor, nurse, and specialist you see has secure access to your electronic medical record, ensuring seamless, informed care at every visit—routine or urgent.

Members can choose how they interact with their care team, with flexible options including:

- In person appointments
- Video visits
- 24-hour advice nurse line, connected directly to your medical record
- Physician email
- Telephone appointments

This integrated approach means your care is always connected and tailored to your needs.

COST TRANSPARENCY & BILLING SUPPORT

Kaiser Permanente helps you better understand and manage your health care costs with tools that make financial planning easier:

- Visit kp.org/costestimates to see personalized estimates for common services based on your benefits and deductible status.
- Call (800) 390-3507 (Monday–Friday, 7 a.m.–5 p.m.) for support with cost information.
- Track your medical bills anytime at kp.org/paymedicalbills, where you can view:
 - Services received
 - Payments made
 - Health plan payments
 - Remaining balances
 - Progress toward your deductible

These tools empower you to plan your care confidently and avoid surprises.

For more information visit <https://choose.kaiserpermanente.org/countyofsonoma/plans>

SUTTER HEALTH PLAN

COMPREHENSIVE COVERAGE

Sutter Health Plan is a local, nonprofit HMO that provides high-quality coverage and connects members to an exceptional network of care, including many of Sutter Health's trusted hospitals and providers.



In Sonoma County, members have convenient access to care through Sutter Medical Group of the Redwoods and Sutter Pacific Medical Foundation. Sutter continues to invest in Sutter Santa Rosa Regional Hospital, expanding services and bringing more providers into the community.

Members also have access to Novato Community Hospital, which serves southern Sonoma County.

FEATURES AND BENEFITS

Take a moment to learn about Sutter Health Plan:

- Comprehensive benefits include coverage for hospitalization, urgent, primary and specialty care, X-rays, laboratory, infertility services, and pharmacy benefits. Some plans also include chiropractic services
- Coverage for a variety of preventive care services at no cost share to help protect against certain health conditions and support early detection
- Reduced cost share for virtual visits
- Easy-to-use online tools, such as:
 - A Member Portal that gives members access to important plan documents; eligibility, benefits and copay information; forms and resources; change primary care physician (PCP); request or print member identification cards
 - My Health Online (not offered by all providers) to schedule appointments and video visits, email doctors, view test results, and access records
- Many Sutter Health Plan network providers use an electronic health record
- Sutter Health Plan partners with CVS Caremark for pharmacy benefits, including retail, mail order and specialty prescription drugs
- Coverage for emergency and urgent care anywhere in the world
- 24/7 Nurse Advice Line with access to registered nurses who can answer medical questions and help you determine the right level of care.
- Access to a variety of health and wellness programs designed to support and maintain healthy lifestyles.

PLAN OFFERINGS

Sutter Health Plan has three plan offerings available for County of Sonoma employees, to meet a variety of needs.

- Traditional HMO – Traditional ML42 HMO
- Hospital Services DHMO – County of Sonoma LG34 HMO
- Deductible First HDHP – County of Sonoma HE09 HDHP HMO

For more information about Sutter Health Plan or to view the plan comparisons, visit <https://www.sutterhealthplan.org/sonoma-county> or call Sutter Health Plan Customer Service (855) 315-5800.

WESTERN HEALTH ADVANTAGE

Headquartered in Sacramento, Western Health Advantage (WHA) is a non-profit HMO health plan founded in 1996. We believe decisions on health care should be made in hospitals not corporate offices. Which is why



at WHA we trust doctors to decide the best health care path for patients. And because we're based locally, not in another state, approvals and decisions are made quickly without delays. It's what happens when a health plan is founded by doctors not accountants.

The WHA provider network includes major hospitals and medical centers and thousands of local, trusted doctors and specialists from reputable medical groups including, **Hill Physicians, Providence Medical, Dignity Health Medical, and NorthBay Healthcare**. With WHA, members have choices for specialist referrals beyond their PCP's medical group.

Enjoy the peace-of-mind that comes with 13 major hospitals and medical centers in Northern California, including four in Sonoma County (**Healdsburg District Hospital, Petaluma Valley Hospital, Santa Rosa Memorial Hospital, and Sonoma Valley Hospital**). You will also find conveniently located full-service care centers that offer a wide array of services under one roof — providing access to quality care in a neighborhood near you.

In addition to your traditional medical benefits, your membership with WHA provides you with these value added benefits:

- Pharmacy Access (**Raley's Rite Aid, Safeway, CVA, Marin Apothecaries**, and others)
- Urgent Care Clinics (**Providence, Carbon Health, Sebastopol** and others)
- **Teladoc Urgent Services** (live doctor for non-emergency, get a diagnosis and a prescription (if needed) in addition to Nurse24, around the clock nurse advice)
- **Assist America**, worldwide travel assistance
- Wellness Resources and Programs including: **Virta, Livongo, Nutritional Counseling, Kaia** as well as **Fitness** center discounts
- Alternative Medicine: **Acupuncture and Chiropractic services** (no referrals needed)
- Behavioral Health and Substance Abuse services available through www.liveandworkwell.com, guest access code: **WHA**

To learn more about Western Health Advantage, visit us at <https://advantage.westernhealth.com/county-of-sonoma> or call (888) 563-2250.

Please Note: Employees who live out of the service area can enroll in WHA as long as the primary workplace is in the service area. Dependents who live outside the service area are not eligible to enroll in WHA, regardless of their work location. Exceptions include Qualified Medical Child Support Order (QMCSO) provided they have access to the service area.

MEDICAL PLANS COMPARISON CHART - COUNTY HEALTH PLANS

CLOSED TO NEW ENROLLEES

County Health Plan - Prudent Buyer EPO

Group #175130M116 (CA)
 Group #175130M120 (Non-CA)
 RxBenefits # RX2169

County Health Plan - Prudent Buyer PPO

Group #175130M108 (CA)
 Group #175130M112 (Non-CA)
 RxBenefits # RX2169

Primary Care Physicians (PCP) and Referrals

PPO plans do not require you to select a PCP. You can access many types of services without receiving a referral or advance approval.

Dependent Children and Adult Dependent Children with Disabilities

Per the Affordable Care Act, dependent children up to age 26 are eligible to enroll as a dependent on your plan. There is no maximum age limit for qualified disabled children. If you believe your child may be eligible to remain on your medical plan due to disability, contact your medical provider for authorization.

General Plan Information

Services	County Health Plan EPO	County Health Plan PPO
Location Requirements for Enrollment Eligibility	Nationwide	Nationwide
Plan Year (June 1 - May 31) Medical Deductible	Individual: \$500 Family: \$1,500	Individual: \$300 Family: \$900
Plan Year Out-of-Pocket Maximum (Including Deductibles, Copays & Coinsurance)	Medical/Prescription Drug Individual: \$5,500/\$1,100 Family: \$11,500/\$1,700	Medical/Prescription Drug Individual: \$2,300/\$1,100 Family: \$4,900/\$1,700

Office Visits and Professional Services

Services	County Health Plan EPO	County Health Plan PPO
Physician & Specialist Office Visits	In-Network: \$50 copay, no deductible Out-of-Network: Not covered	In-Network: \$20 copay, no deductible Out-of-Network: 40% coinsurance, after deductible
Live Health Online	\$10 copay	\$10 copay
Preventive Care Birth to Age 18	In-Network: No charge, no deductible Out-of-Network: Not covered	In-Network: No charge, no deductible Out-of-Network: 40% coinsurance, after deductible
Preventive Care Adult Routine Care	In-Network: No charge, no deductible Out-of-Network: Not covered	In-Network: No charge, no deductible Out-of-Network: 40% coinsurance, after deductible

Office Visits and Professional Services - cont.

Services	County Health Plan EPO	County Health Plan PPO
Preventive Care Adult Routine OB/GYN	In-Network: No charge, no deductible Out-of-Network: Not covered	In-Network: No charge, no deductible Out-of-Network: 40% coinsurance, after deductible
Diagnostic Imaging, Lab and X-ray	In-Network: 20% coinsurance after deductible Out-of-Network: Not covered	In-Network: 10% coinsurance after deductible Out-of-Network: 40% coinsurance, after deductible
Physical Therapy (medically necessary treatment)	In-Network: 20% coinsurance after deductible Out-of-Network: Not covered	In-Network: 10% coinsurance after deductible Out-of-Network: 40% coinsurance, after deductible
Chiropractic and Acupuncture	In-Network: 20% coinsurance after deductible Out-of-Network: Not covered	In-Network: 10% coinsurance after deductible Out-of-Network: 40% coinsurance, after deductible
Mental Health & Substance Use Disorder (outpatient)	In-Network: Office Visit: \$50 copay, no deductible, Other Outpatient: 20% coinsurance after deductible Out-of-Network: Not covered	In-Network: Office Visit: \$20 copay, no deductible, Other Outpatient: 10% coinsurance after deductible Out-of-Network: 40% coinsurance, after deductible
Family Planning Counseling and Consultation	In-Network: \$50 copay, no deductible Out-of-Network: Not covered	In-Network: \$20 copay, no deductible Out-of-Network: 40% coinsurance, after deductible
Routine Eye Exams with Plan Optometrist	In-Network: No charge, no deductible Out-of-Network: Not covered	In-Network: No charge, no deductible Out-of-Network: 40% coinsurance, after deductible
Hearing Exam	In-Network: No charge, no deductible Out-of-Network: Not covered	In-Network: No charge, no deductible Out-of-Network: 40% coinsurance, after deductible
Allergy Injections (serum included)	In-Network: \$50 copay per visit, no deductible Out-of-Network: Not covered	In-Network: \$20 copay per visit, no deductible Out-of-Network: 40% coinsurance, after deductible
Infertility Services	Evaluation (diagnosis) and surgical repair only In-Network: \$50 copay, no deductible Out-of-Network: Not covered	Evaluation (diagnosis) and surgical repair only In-Network: \$20 copay, no deductible Out-of-Network: 40% coinsurance, after deductible

Surgical and Hospital Services

Services	County Health Plan EPO	County Health Plan PPO
Hospitalization and Physician/Surgeon Services	In-Network: \$500 copay plus 20% coinsurance after deductible Out-of-Network: Not covered	In-Network: \$125 per admission copay plus 10% coinsurance after deductible Out-of-Network: \$125 per admission copay plus 40% coinsurance after deductible
Outpatient Surgery	In-Network: \$500 copay plus 20% coinsurance after deductible Out-of-Network: Not covered	In-Network: 10% coinsurance after deductible Out-of-Network: 40% coinsurance after deductible
Maternity	In-Network: \$250 copay plus 20% coinsurance after deductible Out-of-Network: Not covered	In-Network: \$125 per admission copay plus 10% coinsurance after deductible Out-of-Network: \$125 per admission copay plus 40% coinsurance after deductible
Emergency Room	In-Network: \$150 copay plus 20% coinsurance after deductible; Not Covered if non-emergency Out-of-Network: \$150 copay plus 20% coinsurance after deductible; Not Covered if non-emergency (copays waived if admitted)	In-Network: \$100 copay plus 10% coinsurance after deductible; If an emergency Out-of-Network: \$100 copay plus 10% coinsurance after deductible; If an emergency (copays waived if admitted)
Ambulance	In-Network: 20% coinsurance after deductible Out-of-Network: 20% coinsurance after deductible if emergency; otherwise not covered	In-Network: 10% coinsurance after deductible Out-of-Network: 10% coinsurance after deductible if emergency; otherwise not covered
Mental Health & Substance Use Disorder (Inpatient)	In-Network: \$500 copay plus 20% coinsurance after deductible Out-of-Network: Not covered	In-Network: \$125 per admission copay plus 10% coinsurance after deductible Out-of-Network: \$125 per admission copay plus 40% coinsurance after deductible
Skilled Nursing Facility	In-Network: Not covered Out-of-Network: Not covered	In-Network: 10% coinsurance after deductible; up to 100 days per plan year Out-of-Network: 40% coinsurance after deductible; up to 100 days per plan year
Home Health	In-Network: Not covered Out-of-Network: Not covered	In-Network: 10% coinsurance after deductible; up to 100 visits per plan year Out-of-Network: 40% coinsurance after deductible; up to 100 visits per plan year
Urgent Care	In-Network: \$50 copay, no deductible Out-of-Network: Not covered	In-Network: \$20 copay, no deductible Out-of-Network: 40% coinsurance, after deductible
Hearing Aids	One per ear every 36 months	One per ear every 36 months
Durable Medical Equipment	In-Network: 20% coinsurance after deductible Out-of-Network: Not covered	In-Network: 10% coinsurance after deductible Out-of-Network: 40% coinsurance after deductible

Prescription Medication

Services	County Health Plan EPO	County Health Plan PPO
Generic or Tier 1	\$10 copay Up to 34 day supply	\$5 copay Up to 34 day supply
Formulary Brand or Tier 2	\$35 copay Up to 34 day supply	\$20 copay Up to 34 day supply
Non-Formulary Brand or Tier 3	\$70 copay Up to 34 day supply	\$40 copay Up to 34 day supply
Mail Order Benefit Generic or Tier 1	\$20 copay Up to 90 day supply	\$10 copay Up to 90 day supply
Mail Order Benefit Formulary Brand or Tier 2	\$70 copay Up to 90 day supply	\$40 copay Up to 90 day supply
Mail Order Benefit Non- Formulary Brand or Tier 3	\$140 copay Up to 90 day supply	\$80 copay Up to 90 day supply
Mandatory Mail Order	Yes, through RxBenefits	Yes, through RxBenefits
Mandatory Generic Program	Yes	Yes

The information listed in the comparison charts are for reference only. Complete plan information can be found in the Plan Document online at:

<https://sonomacounty.gov/benefit-forms-plan-documents-and-important-information>

MEDICAL PLANS COMPARISON CHART - TRADITIONAL HMO

Kaiser Permanente
Traditional HMO
Group #602484-003

Sutter Health Plan
Traditional HMO
Group #13182-000001

Western Health Advantage
Traditional HMO
Group #950201-A001

Primary Care Physicians and Referrals

HMO plans require you to select a PCP who will work with you to manage your health care needs. You will need to receive advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests.

Dependent Children and Adult Dependent Children with Disabilities

Per the Affordable Care Act, dependent children up to age 26 are eligible to enroll as a dependent on your plan. There is no maximum age limit for qualified disabled children. If you believe your child may be eligible to remain on your medical plan due to disability, contact your medical provider for authorization.

General Plan Information

Services	Kaiser Permanente Traditional HMO	Sutter Health Plan Traditional HMO	Western Health Advantage Traditional HMO
Location Requirements for Enrollment Eligibility	Based on residential zip code. Must live or work in the service area within California	Based on residential zip code. Must live or work in the service area within Northern California	Based on residential zip code. All participants must live or work in the service area within Northern California.
Calendar Year Deductible	None	None	None
Calendar Year Out-of-Pocket Maximum (Including Deductibles, Copays & Coinsurance)	Individual: \$1,500 Any One Member in a family of two or more: \$1,500 Family of two or more: \$3,000	Individual: \$1,500 Any One Member in a family of two or more: \$1,500 Family of two or more: \$3,000	Individual: \$1,500 Any One Member in a family of two or more: \$1,500 Family of two or more: \$3,000

Office Visits and Professional Services

Services	Kaiser Permanente Traditional HMO	Sutter Health Plan Traditional HMO	Western Health Advantage Traditional HMO
Physician & Specialist Office Visits	\$10 copay	\$10 copay Telehealth: \$5 copay	\$10 copay
Preventive Care Birth to Age 18	No charge	No charge	No charge
Preventive Care Adult Routine Care	No charge	No charge	No charge

Office Visits and Professional Services, cont.

Services	Kaiser Permanente Traditional HMO	Sutter Health Plan Traditional HMO	Western Health Advantage Traditional HMO
Preventive Care Adult Routine OB/ GYN	No charge	No charge	No charge
Diagnostic Imaging, Lab and X-ray	No charge	No charge	No charge
Physical Therapy (medically necessary treatment only)	\$10 copay	\$10 copay	\$10 copay
Chiropractic and Acupuncture	Discounted rates through Kaiser One Pass Select Affinity	Chiropractic: \$10 copay Up to 20 visits per year (Chiropractic services do not apply to out-of-pocket maximum) Acupuncture: PCP referral \$10 copay LIMITED benefit for the treatment of nausea or as part of a comprehensive pain management program for chronic pain.	Chiropractic: \$15 copay Up to 20 visits per year - copays do not contribute to out-of-pocket maximum Acupuncture: \$15 copay Up to 20 visits per year
Mental Health & Substance Use Disorder (outpatient office visits)	Individual: \$10 copay Group: \$5 copay	www.carelonbh.com/sutterhealthplan Individual: \$10 copay Virtual Visit: \$5 copy Group: \$5 copay	www.liveandworkwell.com \$10 per office or virtual visit No copay for outpatient services
Family Planning Counseling and Consultation	No charge	No charge	No charge
Routine Eye Exams with Plan Optometrist	No charge	No charge for annual refractive eye exam	No charge
Hearing Exam	No charge	No charge	No charge
Allergy Injections (serum included)	\$3 copay	\$10 copay with a PCP or Specialist (Visits where only an injection is received without seeing a PCP or Specialist are no charge)	\$3 copay
Infertility Services	Infertility services are covered at standard cost share, based on type of service (e.g., office visit, outpatient lab, etc)	Infertility services are covered at standard cost share, based on type of service (e.g., office visit, outpatient lab, etc)	Infertility services are covered at standard cost share, based on type of service (e.g., office visit, outpatient lab, etc)

Surgical and Hospital Services

Services	Kaiser Permanente Traditional HMO	Sutter Health Plan Traditional HMO	Western Health Advantage Traditional HMO
Hospitalization and Physician/Surgeon Services	Facility Fee: No charge Physician/Surgeon Fee: No charge	Facility Fee: No charge Physician/Surgeon Fee: No charge	Facility Fee: No charge Physician/Surgeon Fee: No charge
Outpatient Surgery	\$10 copay	\$10 copay	\$10 copay
Maternity	No charge	No charge	No charge
Emergency Room	\$50 copay (waived if admitted)	\$50 copay (waived if admitted)	\$50 copay (waived if admitted)
Ambulance	\$50 per trip	\$50 per trip	\$50 per trip
Mental Health & Substance Use Disorder (Inpatient)	No charge	www.carelonbh.com/sutterhealthplan No charge	www.liveandworkwell.com No charge
Skilled Nursing Facility	No Charge - Up to 100 days per benefit period	No Charge - Up to 100 days per benefit period	No Charge - Up to 100 days per benefit period
Home Health	No Charge Up to 100 visits per benefit period	No Charge Up to 100 visits per year	No Charge Up to 100 visits per year
Urgent Care	\$10 copay	\$10 copay	\$10 copay
Hearing Aids	Not covered	Not covered	Not covered
Durable Medical Equipment	20% coinsurance in accordance with formulary	No charge	20% coinsurance

Prescription Medication

Services	Kaiser Permanente Traditional HMO	Sutter Health Plan Traditional HMO	Western Health Advantage Traditional HMO
Generic or Tier 1	\$5 copay Up to 100 day supply	\$5 copay Up to 30 day supply	\$5 copay Up to 30 day supply
Formulary Brand or Tier 2	\$10 copay Up to 100 day supply	\$10 copay Up to 30 day supply	\$10 copay Up to 30 day supply
Non-Formulary Brand or Tier 3	Tier 3 - \$10 copay Up to 100 day supply	Tier 3 - \$20 copay Up to 30 day supply	Tier 3 - \$20 copay Up to 30 day supply
Tier 4 Specialty Drug	Tier 4 (Specialty Drug) - \$10 copay, up to 30 day supply	Tier 4 (Specialty Drug) - \$20 copay up to a 30 day supply only	Tier 4 (Specialty and other higher-cost medication) - \$100 copay, up to 30 day supply
Mail Order Benefit Generic or Tier 1	\$5 copay Up to 100 day supply	\$10 copay Up to 100 day supply	\$5 copay Up to 100 day supply
Mail Order Benefit Formulary Brand or Tier 2	\$10 copay Up to 100 day supply	\$20 copay Up to 100 day supply	\$10 copay Up to 100 day supply
Mail Order Benefit Non-Formulary Brand or Tier 3	\$10 copay Up to 100 day supply	\$40 copay Up to 100 day supply	Tier 3 - \$20 copay Up to 100 day supply Tier 4 (Specialty and other higher-cost medication) - \$100 copay, up to 30 day supply
Mandatory Mail Order	No	No	No
Mandatory Generic Program	N/A	Dispense as written program	Yes

The information listed in the comparison charts are for reference only. Complete plan information can be found in the Plan Document online at:

<https://sonomacounty.gov/benefit-forms-plan-documents-and-important-information>

MEDICAL PLANS COMPARISON CHART - HOSPITAL SERVICES

Kaiser Permanente
Hospital Services
Group #602484-006

Sutter Health Plan
Hospital Services
Group #13182-000005

Western Health Advantage
Hospital Services
Group #950201-A001

Primary Care Physicians and Referrals

HMO plans require you to select a PCP who will work with you to manage your health care needs. You will need to receive advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests.

Dependent Children and Adult Dependent Children with Disabilities

Per the Affordable Care Act, dependent children up to age 26 are eligible to enroll as a dependent on your plan. There is no maximum age limit for qualified disabled children. If you believe your child may be eligible to remain on your medical plan due to disability, contact your medical provider for authorization.

General Plan Information

Services	Kaiser Permanente Hospital Services	Sutter Health Plan Hospital Services	Western Health Advantage Hospital Services
Location Requirements for Enrollment Eligibility	Based on residential zip code. Must live or work in the service area within California	Based on residential zip code. Must live or work in the service area within Northern California	Based on residential zip code. All participants must live or work in the service area within Northern California.
Calendar Year Deductible	Individual: \$1,000 Any One Member in a family of two or more: \$1,000 Family of two or more: \$2,000	Individual: \$1,000 Any One Member in a family of two or more: \$1,000 Family of two or more: \$2,000	Individual: \$1,000 Any One Member in a family of two or more: \$1,000 Family of two or more: \$2,000
Calendar Year Out-of-Pocket Maximum (Including Deductibles, Copays & Coinsurance)	Individual: \$3,000 Any One Member in a family of two or more: \$3,000 Family of two or more: \$6,000	Individual: \$3,000 Any One Member in a family of two or more: \$3,000 Family of two or more: \$6,000	Individual: \$3,000 Any One Member in a family of two or more: \$3,000 Family of two or more: \$6,000

Office Visits and Professional Services

Services	Kaiser Permanente Hospital Services	Sutter Health Plan Hospital Services	Western Health Advantage Hospital Services
Physician & Specialist Office Visits	\$20 copay, no deductible	\$20 copay, no deductible Telehealth: \$10 copay, no deductible	\$20 copay, no deductible
Preventive Care Birth to Age 18	No charge, no deductible	No charge, no deductible	No charge, no deductible
Preventive Care Adult Routine Care	No charge, no deductible	No charge, no deductible	No charge, no deductible
Preventive Care Adult Routine OB/GYN	No charge, no deductible	No charge, no deductible	No charge, no deductible

Office Visits and Professional Services, cont.

Services	Kaiser Permanente Hospital Services	Sutter Health Plan Hospital Services	Western Health Advantage Hospital Services
Diagnostic Imaging, Lab and X-ray	Diagnostic Lab: \$10 copay per encounter, no deductible Diagnostic X-ray: \$10 copay per encounter, no deductible CT/PET Scans & MRI: \$50 per procedure, no deductible	Diagnostic Lab: \$20 copay, no deductible Diagnostic X-ray: \$10 copay per procedure, no deductible CT/PET Scans & MRI: \$50 copay per procedure, no deductible	Diagnostic Lab: no charge, no deductible Diagnostic X-ray: no charge, no deductible
Physical Therapy (medically necessary treatment)	\$20 copay, no deductible	\$20 copay, no deductible	\$20 copay, no deductible
Chiropractic and Acupuncture	Discounted rates through Kaiser One Pass Select Affinity	Chiropractic: \$20 copay, no deductible. Up to 20 visits per year (Chiropractic services do not apply to out-of-pocket maximum) Acupuncture: PCP referral \$20 copay, no deductible. LIMITED benefit for the treatment of nausea or as part of pain management program for chronic pain.	Chiropractic: \$15 copay, no deductible. Up to 20 visits per year - copays do not contribute to out-of-pocket maximum Acupuncture: \$15 copay, no deductible. Up to 20 visits per year
Mental Health & Substance Use Disorder (outpatient office visits)	MH/SUD individual , \$20 copay, no deductible MH group , \$10 copay, no deductible SUD group , \$5 copay, no deductible	www.carelonbh.com/sutterhealthplan MH/SUD individual , \$20 copay, no deductible Virtual Visit , \$10 copay, no deductible MH/SUD group , \$10 copay, no deductible	www.liveandworkwell.com \$20 copay per office or virtual visit No copay, no deductible, for Outpatient services
Family Planning Counseling and Consultation	No charge, no deductible	No charge, no deductible	\$20 copay, no deductible
Routine Eye Exams with Plan Optometrist	No charge, no deductible	No charge for annual refractive eye exam	No charge, no deductible
Hearing Exam	No charge, no deductible	No charge, no deductible	No charge, no deductible
Allergy Injections (serum included)	No charge, no deductible	\$20 copay, no deductible with a PCP or Specialist (Visits where only an injection is received without seeing a PCP or Specialist are no charge, no deductible)	No charge, no deductible
Infertility Services	Infertility services are covered at standard cost share, based on type of service (e.g., office visit, outpatient lab, etc)	Infertility services are covered at standard cost share, based on type of service (e.g., office visit, outpatient lab, etc)	Infertility services are covered at standard cost share, based on type of service (e.g., office visit, outpatient lab, etc)

Surgical and Hospital Services

Services	Kaiser Permanente Hospital Services	Sutter Health Plan Hospital Services	Western Health Advantage Hospital Services
Hospitalization and Physician/Surgeon Services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient Surgery	20% coinsurance after deductible	20% coinsurance after deductible	In Office - \$20 copay per visit, no deductible In Facility - 20% coinsurance after deductible
Maternity	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Emergency Room	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Ambulance	\$150 per trip, no deductible	No charge after deductible	\$150 per trip, no deductible
Mental Health & Substance Use Disorder (Inpatient)	20% coinsurance after deductible	www.carelonbh.com/sutterhealthplan 20% coinsurance after deductible	www.liveandworkwell.com 20% coinsurance after deductible
Skilled Nursing Facility	20% coinsurance, no deductible, up to 100 days per benefit period	20% coinsurance, after deductible, up to 100 days per benefit period	20% coinsurance, after deductible, up to 100 days per benefit period
Home Health	No charge, no deductible, up to 100 visits per benefit period	No charge, no deductible Up to 100 visits per calendar year	No charge, no deductible, up to 100 visits per year
Urgent Care	\$20 copay, no deductible	\$20 copay, no deductible	\$20 copay, no deductible
Hearing Aids	Not covered	Not covered	Not covered
Durable Medical Equipment	20% coinsurance in accordance with formulary, no deductible	20% coinsurance after deductible	20% coinsurance, no deductible Medically necessary orthotic and prosthetic devices - \$20 copay

Prescription Medication			
Services	Kaiser Permanente Hospital Services	Sutter Health Plan Hospital Services	Western Health Advantage Hospital Services
Generic or Tier 1	\$10 copay, no deductible Up to 30 day supply	\$10 copay, no deductible Up to 30 day supply	\$10 copay, no deductible Up to 30 day supply
Formulary Brand or Tier 2	\$30 copay, no deductible Up to 30 day supply	\$30 copay, no deductible Up to 30 day supply	\$30 copay, no deductible Up to 30 day supply
Non-Formulary Brand or Tier 3 Tier 4 Specialty Drugs	Tier 3 - \$30 copay, no deductible, up to 30 day supply Tier 4 (Specialty Drug) - \$30 copay, no deductible, up to 30 day supply	Tier 3 - \$60 copay, no deductible Up to 30 day supply Tier 4 (Specialty Drug) - 20% coinsurance up to a maximum of \$100 per prescription, no deductible, up to 30 day supply	Tier 3 - \$50 copay, no deductible Up to 30 day supply Tier 4 (Specialty and other higher-cost medication) - \$100 copay, no deductible, up to 30 day supply
Mail Order Benefit Generic or Tier 1	\$20 copay, no deductible Up to 100 day supply	\$20 copay, no deductible Up to 100 day supply	\$20 copay, no deductible Up to 100 day supply
Mail Order Benefit Formulary Brand or Tier 2	\$60 copay, no deductible Up to 100 day supply	\$60 copay, no deductible Up to 100 day supply	\$60 copay, no deductible Up to 100 day supply
Mail Order Benefit Non-Formulary Brand or Tier 3	\$60 copay, no deductible Up to 100 day supply	\$120 copay, no deductible Up to 100 day supply	Tier 3 - \$100 copay, no deductible Up to 100 day supply Tier 4 (Specialty and other higher-cost medication) - \$100 copay, no deductible, up to 30 day supply
Mandatory Mail Order	No	No	No
Mandatory Generic Program	N/A	Dispense as written program	Yes

The information listed in the comparison charts are for reference only. Complete plan information can be found in the Plan Document online at:

<https://sonomacounty.gov/benefit-forms-plan-documents-and-important-information>

MEDICAL PLANS COMPARISON CHART - DEDUCTIBLE FIRST

Kaiser Permanente
Deductible First
Group #602484-009

Sutter Health Plan
Deductible First
Group #13182-000009

Western Health Advantage
Deductible First
Group #950201-A001

Primary Care Physicians and Referrals

HMO plans require you to select a PCP who will work with you to manage your health care needs. You will need to receive advance approval from the medical group or health plan for some services, such as treatment by a specialist or certain types of tests.

Dependent Children and Adult Dependent Children with Disabilities

Per the Affordable Care Act, dependent children up to age 26 are eligible to enroll as a dependent on your plan. There is no maximum age limit for qualified disabled children. If you believe your child may be eligible to remain on your medical plan due to disability, contact your medical provider for authorization.

General Plan Information

Services	Kaiser Permanente Deductible First	Sutter Health Plan Deductible First	Western Health Advantage Deductible First
Location Requirements for Enrollment Eligibility	Based on residential zip code. Must live or work in the service area within California	Based on residential zip code. Must live or work in the service area within Northern California	Based on residential zip code. All participants must live or work in the service area within Northern California.
Calendar Year Deductible	Individual: \$1,700 Any One Member in a family of two or more: \$3,400 Family of two or more: \$3,400	Individual: \$1,700 Any One Member in a family of two or more: \$3,400 Family of two or more: \$3,400	Individual: \$1,700 Any One Member in a family of two or more: \$3,400 Family of two or more: \$3,400
Calendar Year Out-of-Pocket Maximum (Including Deductibles, Copays & Coinsurance)	Individual: \$3,400 Any One Member in a family of two or more: \$3,400 Family of two or more: \$6,800	Individual: \$3,400 Any One Member in a family of two or more: \$3,400 Family of two or more: \$6,800	Individual: \$3,400 Any One Member in a family of two or more: \$3,400 Family of two or more: \$6,800

Office Visits and Professional Services

Services	Kaiser Permanente Deductible First	Sutter Health Plan Deductible First	Western Health Advantage Deductible First
Physician & Specialist Office Visits	\$20 copay after deductible	\$20 copay after deductible Telehealth: \$10 copay, after deductible	\$20 copay after deductible
Preventive Care Birth to Age 18	No charge, no deductible	No charge, no deductible	No charge, no deductible
Preventive Care Adult Routine Care	No charge, no deductible	No charge, no deductible	No charge, no deductible
Preventive Care Adult Routine OB/GYN	No charge, no deductible	No charge, no deductible	No charge, no deductible

Office Visits and Professional Services, cont.

Services	Kaiser Permanente Deductible First	Sutter Health Plan Deductible First	Western Health Advantage Deductible First
Diagnostic Imaging, Lab and X-ray	Diagnostic Lab: \$10 copay per encounter after deductible Diagnostic X-ray: \$10 copay per encounter after deductible CT/PET Scans & MRI: \$50 per procedure after deductible	Diagnostic Lab: \$20 copay after deductible Diagnostic X-ray: \$10 copay per procedure after deductible CT/PET Scans & MRI: \$50 copay per procedure after deductible	No charge after deductible
Physical Therapy (medically necessary treatment)	\$20 copay after deductible	\$20 copay after deductible	\$20 copay after deductible
Chiropractic and Acupuncture	Discounted rates through Kaiser One Pass Select Affinity	Chiropractic: Not covered Acupuncture: PCP referral \$20 copay after deductible LIMITED benefit for the treatment of nausea or as part of pain management program for chronic pain.	No charge after deductible Up to 20 visits per year
Mental Health & Substance Use Disorder (outpatient office visits)	MH/SUD individual , \$20 copay after deductible MH group , \$10 copay after deductible SUD group , \$5 copay after deductible	www.carelonbh.com/sutterhealthplan MH/SUD individual , \$20 copay per visit, after deductible Virtual Visit , \$10 copay after deductible MH/SUD group , \$10 copay per visit, after deductible	www.liveandworkwell.com \$20 copay after deductible per office or virtual visit No copay, after deductible, for Outpatient services
Family Planning Counseling and Consultation	No charge, no deductible	No charge, no deductible	\$20 copay after deductible
Routine Eye Exams with Plan Optometrist	\$20 copay after deductible	No charge for annual refractive eye exam	No charge, no deductible
Hearing Exam	No charge, no deductible	No charge, no deductible	No charge, no deductible
Allergy Injections (serum included)	\$5 copay after deductible	\$20 copay after deductible with PCP or Specialist (Visits where only an injection is received without seeing a PCP or Specialist are no charge, after deductible)	\$5 copay after deductible
Infertility Services	Infertility services are covered at standard cost share, based on type of service (e.g., office visit, outpatient lab, etc)	Infertility services are covered at standard cost share, based on type of service (e.g., office visit, outpatient lab, etc)	Infertility services are covered at standard cost share, based on type of service (e.g., office visit, outpatient lab, etc)

Surgical and Hospital Services

Services	Kaiser Permanente Deductible First	Sutter Health Plan Deductible First	Western Health Advantage Deductible First
Hospitalization and Physician/Surgeon Services	\$250 copay per admission after deductible Inpatient Physician Services: No charge after deductible	Hospitalization Facility Fee: \$250 copay per day, up to 5 days per admission after deductible Inpatient Physician Services: No charge after deductible	\$250 copay per admission after deductible Inpatient Physician Services: No charge after deductible
Outpatient Surgery	\$150 copay per procedure after deductible	\$20 copay per visit after deductible	\$150 copay per procedure after deductible
Maternity	\$250 copay per admission after deductible	\$250 copay per day up to a maximum of 5 days per admission after deductible	\$250 copay per admission after deductible
Emergency Room	\$100 copay after deductible	\$100 copay after deductible	\$100 copay after deductible
Ambulance	\$100 copay per trip, after deductible	\$100 copay per trip, after deductible	\$100 copay per trip, after deductible
Mental Health & Substance Use Disorder (Inpatient)	\$250 copay per admission after deductible	www.carelonbh.com/sutterhealthplan MH/SUD Inpatient Facility: \$250 copay per day, up to 5 days per admission after deductible MH/SUD Inpatient Physician Services: No charge after deductible	www.liveandworkwell.com \$250 copay per admission after deductible
Skilled Nursing Facility	\$250 copay per admission after deductible, up to 100 days per benefit period	\$100 copay per day up to 5 days per admission after deductible Up to 100 days per benefit period	\$250 copay per admission after deductible, up to 100 days per benefit period
Home Health	No charge after deductible Up to 100 visits per benefit period	No charge after deductible Up to 100 visits per year	No charge after deductible Up to 100 visits per year
Urgent Care	\$20 copay after deductible	\$20 copay after deductible	\$20 copay after deductible
Hearing Aids	Not covered	Not covered	Not covered
Durable Medical Equipment	20% coinsurance in accordance with formulary after deductible	20% coinsurance after deductible	20% coinsurance after deductible

Prescription Medication			
Services	Kaiser Permanente Deductible First	Sutter Health Plan Deductible First	Western Health Advantage Deductible First
Generic or Tier 1	\$10 copay after deductible Up to 30 day supply	\$10 copay after deductible Up to 30 day supply	\$10 copay after deductible Up to 30 day supply
Formulary Brand or Tier 2	\$30 copay after deductible Up to 30 day supply	\$30 copay after deductible Up to 30 day supply	\$30 copay after deductible Up to 30 day supply
Non-Formulary Brand or Tier 3 Tier 4 Specialty Drug	Tier 3 - \$30 copay after deductible, up to 30 day supply Tier 4 (Specialty Drug) - \$30 copay after deductible, up to 30 day supply	Tier 3 - \$60 copay after deductible Up to 30 day supply Tier 4 (Specialty Drug) - 20% coinsurance up to a maximum of \$100 per prescription after deductible, up to 30 day supply	Tier 3 - \$50 copay after deductible Up to 30 day supply Tier 4 (Specialty and other higher-cost medication) - \$100 copay after deductible, up to 30 day supply
Mail Order Benefit Generic or Tier 1	\$20 copay after deductible Up to 100 day supply	\$20 copay after deductible Up to 100 day supply	\$20 copay after deductible Up to 100 day supply
Mail Order Benefit Formulary Brand or Tier 2	\$60 copay after deductible Up to 100 day supply	\$60 copay after deductible Up to 100 day supply	\$60 copay after deductible Up to 100 day supply
Mail Order Benefit Non-Formulary Brand or Tier 3	\$60 copay after deductible Up to 100 day supply	\$120 copay after deductible Up to 100 day supply	Tier 3 - \$100 copay after deductible Up to 100 day supply Tier 4 (Specialty and other higher-cost medication) - \$100 copay after deductible, up to 30 day supply
Mandatory Mail Order	No	No	No
Mandatory Generic Program	N/A	Dispense as written program	Yes

The information listed in the comparison charts are for reference only. Complete plan information can be found in the Plan Document online at:

<https://sonomacounty.gov/benefit-forms-plan-documents-and-important-information>

DENTAL BENEFITS

Dental coverage is an important part of your benefits package and regular dental care is key to your overall health. The County is pleased to offer Delta Dental PPO™ as your dental plan option.



The Delta Dental PPO™ network is available Nationwide and allows you the freedom to visit any licensed dentist or specialist of your choice. Participating dentists have agreed to accept pre-negotiated fees for dental procedures, and are prohibited from billing a patient above the predetermined amount (balance billing). This arrangement results in protection and savings for patients.

Note: Dentistry has changed in recent years and continues to change on a regular basis. Much of this change is due to new materials, new technology, and new scientific discoveries, as well as changes in the way dentists run their practices. It's the dentist's responsibility to inform the patient about all of the reasonable and appropriate services that are available, regardless of the patient's dental coverage. It's the patient's responsibility to ask the right questions about these options and treatment.

Always request your dentist to submit a pre-treatment estimate to Delta Dental before having major dental work done. Don't be afraid to ask questions! Do not agree to any treatment unless you fully understand what condition is being treated, why it is being treated, and the costs of that treatment. When in doubt, contact Delta Dental.

To learn more about Delta Dental, visit us at www.DeltaDentalIns.com or call (888) 335-8227.

HOW THE DENTAL PLAN WORKS

The information in this benefits guide is only a summary of the plan benefits. For more detailed information, refer to the plan's evidence of coverage booklets, available through the County of Sonoma web site at: <https://sonomacounty.gov/benefit-forms-plan-documents-and-important-information>.

Take note... The benefit plan year is June 1-May 31. The deductible is on a calendar year basis, from January 1 through December 31. This means your deductible and plan maximum benefit levels accumulate over the calendar year and start over as of January 1 each year.

Delta Dental PPO™ is underwritten by Delta Dental of California in CA. Delta Dental is a registered trademark of Delta Dental Plans Association.

2026-2027 DENTAL PREMIUMS

Payroll premium deductions for eligible full-time employees' dental coverage vary based on bargaining unit, as noted in the table below. The County contribution for dental coverage provided to eligible part-time employees is pro-rated, as described elsewhere in this booklet.



Bargaining Unit	Employee Contribution	County Contribution	Total Semi-Monthly Premium Cost
DSA, DSLEM, SCDPDAA, SCPA, SEIU, Salary Resolution	\$14.13	\$44.29	\$58.42
ESC, Local 39, SCLEA, SCLEMA, SCPDIA	\$13.04	\$45.38	\$58.42
WCE	\$25.00	\$33.42	\$58.42

DELTA DENTAL PPO PLAN BENEFIT HIGHLIGHTS

Delta Dental PPO™ Group #03126

Dental Services	All Units
Diagnostic & Preventive	Plan pays 100% of allowable charges; an extra annual dental exam and cleaning is included during pregnancy
Basic Dental Services	Plan pays 80% of allowable charges
Crowns & Cast Restorations	Plan pays 80% of allowable charges
Prosthodontics	Plan pays 80% of allowable charges; coverage for implants is included under the plan
Orthodontics	Plan pays 50% of allowable charges, up to a lifetime maximum of \$6,000 per member
Deductible	\$0
Calendar Year Maximum Dental Benefits	\$3,000 per person per calendar year; Diagnostic and Preventative benefits are exempt from the calendar year maximum only when received from a Delta Dental PPO™ provider.

VISION BENEFITS

Get the best in eye care and eyewear with COUNTY OF SONOMA and VSP® Vision Care.



At VSP, we invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we’re the only national not-for-profit vision care company, you can trust that we’ll always put your wellness first.

You’ll like what you see with VSP...

Value and Savings. You’ll enjoy more value and the lowest out-of-pocket costs.

High Quality Vision Care. You’ll get the best care from a VSP provider, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, your satisfaction is guaranteed.

Choice of Providers. The decision is yours to make—choose a VSP provider or any out-of-network provider.

Great Eyewear. It’s easy to find the perfect frame at a price that fits your budget.

2026-2027 VISION PREMIUMS

Vision premiums are paid in full by the County for full-time employees, and premiums are pro-rated for eligible part-time employees. Vision coverage cannot be waived by eligible full-time employees.

Bargaining Unit	Employee Contribution	County Contribution	Total Semi-Monthly Premium Cost
All Units	\$0.00	\$7.15	\$7.15

VISION SERVICE PLAN (VSP) BENEFIT HIGHLIGHTS

VSP Group #12437001-0025

Benefit	Description	Copay	Frequency
WellVision Exam	<ul style="list-style-type: none"> Focuses on your eyes and overall wellness KIDSCARE: Provides up to 2 fully covered \ WellVision exams, if needed 	\$0	Every 12 months
Prescription Glasses - Frame	<ul style="list-style-type: none"> \$150 allowance for a wide selection of frames \$170 allowance for featured frame brands like Anne Klein, Bebe*, Calvin Klein, Flexon*, Lacoste, Nike, Nine West, and more 20% savings on the amount over your allowance \$150 allowance for Costco, Walmart and Sam’s Club frames KIDSCARE: Frames every 12 months / \$150 allowance or \$170 allowance for featured frame brands 	\$0	Every 24 months
Prescription Glasses - Lenses	<ul style="list-style-type: none"> Single vision, lines bifocal, and lined trifocal lenses KIDSCARE: Lenses every 12 months, plus additional lenses with a prescription change Polycarbonate lenses for dependent children 	\$0	Every 12 months

Benefit	Description	Copay	Frequency
Prescription Glasses - Lens Enhancements	<ul style="list-style-type: none"> • REPAIR & REPLACE: Lenses and frames needing repair or replacement if damaged or broken - frames covered up to allowances • Average savings of 40% on other lens enhancements 	\$0	Every 12 months
Prescription Glasses - Contacts (instead of glasses)	<ul style="list-style-type: none"> • \$130 allowance for contacts and contact lens exams (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation) 	\$0	Every 12 months
Essential Medical Eyecare	<ul style="list-style-type: none"> • Covered in full retinal screening for members who have diabetes but don't show signs of diabetic eye disease • Additional exams and services for members with diabetes, glaucoma, or age related macular degeneration. \$20 copay per exam 	\$20	As needed
Employee Only Computer Vision Care - Frame	<ul style="list-style-type: none"> • \$125 allowance for a wide selection of frames • \$145 allowance for featured frame brands • 20% savings on the amount over your allowance 	\$0	Every 24 months
Employee Only Computer Vision Care - Lenses	<ul style="list-style-type: none"> • Single vision, lined bifocal, lines trifocal, and occupational lenses 	\$0	Every 12 months

EXTRA SAVINGS

Glasses and Sunglasses

- Extra \$20 to spend on featured frame brands. Go to www.vsp.com/specialoffers for details.
- 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.

Retinal Screening

- No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam

Laser Vision Correction

- Average 15% off the regular price of 5% off the promotional price; discounts only available from contracted facilities.
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Visit vsp.com for details, if you plan to see a provider other than a VSP network provider.

- Exam - up to \$45
- Frame - up to \$45
- Single Vision Lenses - up to \$45
- Contacts - up to \$105
- Lined Bifocal Lenses - up to \$65
- Lined Trifocal Lenses - up to \$85
- Progressive Lenses - up to \$85

VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on application laws, benefits may vary by location.

LIFE INSURANCE

BASIC AND SUPPLEMENTAL LIFE INSURANCE

Basic Life, Accidental Death & Dismemberment (AD&D), Supplemental Life and Dependent Life Insurances are insured by Hartford Life Insurance.

- All regular full-time employees and regular part-time employees, in an allocated position of 60 hours (.75 FTE) or more per pay period, receive basic life insurance and AD&D benefits paid by the County and are eligible to purchase supplemental and dependent life insurance at their own expense.
- Part-time DSA, SCLEA, and ESC employees working less than 60 hours per pay period may purchase basic, supplemental, and dependent life insurance at their own expense.
 - ESC can purchase \$25,000 in basic life (includes AD&D) for \$0.48 bi-weekly
 - DSA can purchase \$100,000 in basic life (includes AD&D) for \$1.90 bi-weekly
 - SCLEA can purchase 1 time their base annual salary of basic life (includes AD&D) at a rate of \$0.19 per \$1,000 in coverage bi-weekly
- Employees must be enrolled in basic life insurance to be eligible to purchase supplemental and dependent life insurance.
- The amount of Supplemental Life insurance you can elect is determined by your bargaining unit and cannot exceed a combined basic and supplemental life election of \$500,000.

GUARANTEE ISSUE

Guarantee Issue is the amount of Supplemental Life Insurance that you are automatically approved for without providing evidence of good health. Guarantee issue is up to the lesser of 3x your basic life amount or \$250,000.

Newly hired or newly eligible employees

If you are a new hire or newly eligible employee and submit your election within 31 days of eligibility, you are eligible for a guarantee issue. Requested elections that exceed the lesser of 3x your basic life amount or \$250,000 require completion of an Evidence of Insurability (EOI) form submitted directly to Hartford for approval.

During Annual Enrollment

- For the 2026-2027 Annual Enrollment period only, there is a one time special enrollment that will allow you to enroll in supplemental life insurance up to the guaranteed issue amount without completing an EOI.

LEVELS OF COVERAGE

Hartford Life Insurance		
Bargaining Units	Basic Life and AD&D Insurance 100% Paid by the County*	Supplemental Life Employee Paid **
Unrepresented (00)	1.5 times the Base Annual Salary	Increments of \$10,000
DSA (46, 47)	\$100,000	Increments of \$10,000
Confidential (51)	1.5 times the Base Annual Salary	1, 2, 3 or 4 times your Basic Life Amount
Administrative Management (50) Board of Supervisors (49) Department & Agency Heads (52) DSLEM (43), SCDPDAA (60) SCLEMA (44), SCPA (45)	2 times the Base Annual Salary	1, 2, 3 or 4 times your Basic Life Amount
SEIU (01, 05, 10, 25, 80, 95), Local 39 (85) SCLEA (30, 40, 41, 70), SCPDIA (55)	1 time the Base Annual Salary	Increments of \$10,000
WCE (21)	1 time the Base Annual Salary	1, 2, 3 or 4 times your Base Annual Salary
ESC (75)	\$25,000	1, 2, 3, 4 or 5 times your Base Annual Salary

* Part-time employees working less than 60 hours per pay period in DSA, ESC, SCLEA bargaining unit are responsible for the full premium if they elect coverage.

** The maximum amount of Life Insurance, Basic Life and Supplemental Life combined, cannot exceed \$500,000.

SUPPLEMENTAL LIFE INSURANCE COST

The cost of supplemental coverage is based on your age and the amount of insurance you elect. Current rates for each \$10,000 in supplemental life insurance coverage are listed in the table to the right.

Insurance amounts are rounded to the nearest thousandth.

2026-2027 Employee Supplemental Life Insurance Premiums per \$10,000 of Coverage		
Age*	Bi-Weekly Rate	Annual Rate
29 and under	\$0.28	\$7.20
30-34	\$0.31	\$8.17
35 – 39	\$0.39	\$10.20
40 – 44	\$0.59	\$15.37
45 – 49	\$0.86	\$22.44
50 – 54	\$1.37	\$35.77
55 – 59	\$2.28	\$59.40
60 – 64	\$3.38	\$88.08
65 – 69	\$5.53	\$144.35
70 and over	\$10.12	\$264.13

*Age band rate changes take effect January 1st and are based on the age you will become during the calendar year.

Example: 30 year old employee enrolled in \$20,000 of supplemental life insurance: \$0.31 x 2 (chart price is for each \$10K) = \$0.62 each pay period; \$16.34 per year.

DEPENDENT LIFE INSURANCE

You can also purchase dependent life insurance coverage for your spouse/domestic partner and any dependent child through the end of the month they turn age 26. The benefit provided for dependent coverage is \$5,000 for each eligible family member. The premium is \$0.23 bi-weekly; which covers all eligible members of your family. You must have basic life insurance coverage in order to purchase dependent life insurance.

The benefit provided for dependent coverage is a payment to the employee of \$5,000 for each eligible family member.

The County does not maintain a list of eligible dependents enrolled in dependent life insurance. You will need to provide proof of eligibility upon submitting a claim.

KEY POINTS TO CONSIDER ABOUT LIFE INSURANCE

- You pay the full cost of supplemental and dependent coverage on a post-tax basis.
- Especially if you are the sole wage-earner in your family, think about whether or not you need more protection than the County-paid basic coverage provides.
- Consider whether you have enough money to cover funeral and/or legal expenses in the event of a death of a spouse, domestic partner, or child(ren). Dependent life insurance may help with these expenses.
- Be sure to designate a beneficiary (or beneficiaries) for your employee life insurance and keep them up-to-date (basic and supplemental). The Hartford Beneficiary Form is located in the main menu of Employee Self Service and on the Employee Benefits webpage at <https://sonomacounty.gov/benefit-forms-plan-documents-and-important-information>.



EMPLOYEE ASSISTANCE PLAN

All County of Sonoma employees, including part time and extra help employees, and their family members are eligible for the Employee Assistance Plan (EAP).



A family member is any individual living with the employee, including, but not limited to a spouse, child(ren), grandchild(ren), domestic partners, parents, and grandparents. Children living away from home are also eligible for EAP. Nannies, housekeepers, or other domestic help living with the employee are not considered family members.

You don't have to handle your concerns on your own. It's OK to ask for help. In fact, seeking help early enables you to take immediate control of your situation and can prevent small issues from turning into big problems. Benefits include:

- Six (6) face-to-face, phone, or virtual visits with a counselor per situation
- Legal and Financial Services
- Work/Life Services
- Online Resources and Tools

OBTAIN AN AUTHORIZATION CODE

EAP is a confidential service available at no cost to you and your family 24 hours a day, 365 days a year. You will need to receive an authorization code prior to contacting a counselor. To obtain an authorization code, call (866) 248-4096.

The authorization code is your insurance authorization for the approved sessions. It is important to provide the authorization code to the counselor prior to beginning any sessions to ensure proper billing. Without the authorization code, you and/or your medical insurance will be billed for the counseling services rather than EAP.

FIND A COUNSELOR

Once you receive an authorization code you are ready to contact an in-network licensed counselor.

For faster access to a licensed counselor and more flexibility, try TalkSpace. TalkSpace is an online platform that allows you to meet with a licensed counselor virtually.

For more information about these options and to find an in-network licensed counselor, visit www.liveandworkwell.com. Click on "Browse with an access code" and enter "Sonoma". At the login prompt, create a username. It can be any name or word of your choosing. You do not need to create a password.

Suicide and Crisis Lifeline: Call or Text 988

MID YEAR CHANGES

Elections shall be effective prospectively. Generally, elections that add or change coverage will be effective on the first day of the month following or coinciding with the date the completed Employee Enrollment/Change Form is received by the Human Resources Benefits Unit. (The exception is that when enrollment is requested for a newborn, newly adopted child or child placed for adoption, coverage is effective on the date of birth or adoption or placement for adoption). For New Hires, elections are effective on the first day of the month following the date of hire in a benefits-eligible position, including those hired on the first day of the month.

Elections that cancel or drop coverage will be effective on the last day of the month following or coinciding with the date the completed Employee Enrollment/Change Form is received by the Human Resources Benefits Unit.

If your coverage was terminated or lapsed while on leave, you will need to complete a new Employee Enrollment/Change Form upon return from your leave. Your coverage will be effective on the first day of the month following your return from leave and receipt of the enrollment form. If you are returning from a Military leave of absence, your coverage will be effective on the date you return from leave.

You will be billed for any premiums owed as a result of your re-enrollment and for the addition of any eligible dependents. If the Change-in-Status event results in a decrease in premiums, you will receive a refund on a subsequent pay for the premium overpayment. To reduce the amount of premiums owed or to avoid incurring an overpayment of premiums, you are encouraged to submit your paperwork as soon as possible.



NEWBORN CHILDREN

Newborn children must be enrolled in County plan coverage, including medical, dental and vision, to receive benefits under the plan. Failure to request enrollment for your newborn in a County plan within 31 days of the date of birth will result in your newborn not having coverage from date and time of birth forward for most plans. You will be liable for any services and/or expenses incurred for that newborn who is not timely and properly enrolled.

To enroll your newborn, submit a completed Employee Election/Change Form to the Human Resources Benefits Unit. When enrollment is requested timely, coverage must be retroactively effective to the date of birth, adoption or placement for adoption. You are encouraged to request newborn enrollment and submit enrollment paperwork as soon as possible (and no later than 31 days after the date of birth) to avoid non-coverage for your newborn child.

When properly enrolled, the newborn will be assigned under the medical group to which the parent is assigned for the first 30 days following birth; after 30 days they will be assigned to the physician/group designated on the enrollment form.

Mid year changes must be submitted within 31 days of the event date!



You will be required to provide proof of the mid-year event for all changes

Per IRS regulations, changes must be consistent with the event type. See Change of Status and Mid-Year Changes chart to determine what changes you are eligible for.

CHANGE OF STATUS EVENTS AND MID-YEAR ENROLLMENT CHANGES

Change of status or eligibility changes permitted in accordance with Section 125 of the Internal Revenue Code. This chart is only a summary of some of the permitted health plan changes and is not all inclusive.

Life and Family Events		
If you experience the following event...	You may make the following change(s) within 31 days of the event...	YOU MAY NOT make these types of Changes
Marriage or Commencement of Domestic Partnership (DP)	<ul style="list-style-type: none"> • Enroll yourself, if applicable • Enroll your new spouse/DP and other eligible dependents • Drop health coverage (to enroll in your spouse/DP's plan) • Change health plans 	Drop health coverage and not enroll in spouse/DP's plan
Divorce, Legal Separation, or Termination of Domestic Partnership	<ul style="list-style-type: none"> • Drop your spouse/DP from your health coverage • Drop dependent child(ren) with proof of other coverage under spouse's plan • Children of a Domestic Partner MUST be dropped (regardless of whether they enroll in other coverage) as they are no longer eligible dependents • Enroll yourself and your dependent children if you or at least one dependent child was previously enrolled in your spouse/DP's plan and lost eligibility • Change health plans 	Drop health coverage for yourself
Gain a child due to birth or adoption	<ul style="list-style-type: none"> • Enroll yourself, if not enrolled and adding the newly eligible child(ren) • Enroll the eligible child and any other eligible dependents • Change health benefit plans * Adoption placement papers are required 	<ul style="list-style-type: none"> • Drop health coverage for yourself or any other covered individuals without proof of enrollment in spouse/DP's plan
Child requires coverage due to a Qualified Medical Child Support Order (QMCSO)	<ul style="list-style-type: none"> • Add child named on QMCSO to your health coverage (enroll yourself, if applicable and not already enrolled) • Drop child named on QMCSO if required by QMCSO • Change health plans, when options are available, to accommodate the child named on the QMCSO 	<ul style="list-style-type: none"> • Drop health coverage for yourself • Make any other changes except as required by the QMCSO

Life and Family Events, cont.

If you experience the following event...	You may make the following change(s) within 31 days of the event...	YOU MAY NOT make these types of Changes
Loss of a child's eligibility (e.g. child reaches the maximum age for coverage) or death of a dependent child	<ul style="list-style-type: none"> • Drop the child who lost eligibility from your health coverage • Change health plans to accommodate newly removed dependent(s) and remaining covered individuals 	<ul style="list-style-type: none"> • Drop health coverage for yourself or any other covered individuals
Death of a spouse/DP	<ul style="list-style-type: none"> • Drop the deceased dependent from your health coverage • Enroll yourself and/or any eligible children if lost eligibility under spouse's/DP's plan • Change health plans 	<ul style="list-style-type: none"> • Drop health coverage for yourself or any other covered individuals
Change of home address outside of plan service area that causes a loss of eligibility for coverage	<ul style="list-style-type: none"> • Change health plans if you are enrolled in a medical HMO and move out of their service area 	<ul style="list-style-type: none"> • Cannot add eligible dependents • Does not apply to County Health Plan, dental or vision coverage

Medicare/SCHIP/Medicaid/CHIP Events

If you experience the following event...	You may make the following change(s) within 60 days of the event...	YOU MAY NOT make these types of Changes
Covered person has become entitled to Medicare	<ul style="list-style-type: none"> • Drop coverage for the Dependent who became entitled to Medicare, with proof of Medicare enrollment • If Employee becomes entitled to Medicare, may drop all coverage (self and dependents) * Documentation required 	<ul style="list-style-type: none"> • Drop health coverage for yourself or any other covered individuals who are not newly Medicare, Medicaid, Medi-Cal, or SCHIP eligible • Change Plans • Enroll yourself
Covered person has lost entitlement to Medicare	<ul style="list-style-type: none"> • Add coverage for the Dependent who lost entitlement to Medicare, with proof of Medicare dis-enrollment 	<ul style="list-style-type: none"> • Change Plans
Covered person has become entitled to Medicaid, Medi-Cal, or SCHIP	<ul style="list-style-type: none"> • Drop coverage for the Dependent who became entitled to Medicaid, Medi-Cal, or SCHIP with proof of Medicaid/ Medi-Cal or SCHIP enrollment • Drop coverage for yourself with proof of your own Medicaid/Medi-Cal/SCHIP enrollment • If you or an eligible dependent is gaining eligibility for premium assistance, may enroll those gaining eligibility for premium assistance only if not already enrolled in County coverage * Documentation required 	<ul style="list-style-type: none"> • Drop health coverage for yourself or any other covered individuals who are not newly Medicaid, Medi-Cal, or SCHIP eligible • Change Plans • Enroll yourself
Covered person lost entitlement to Medicaid, Medi-Cal or SCHIP	<ul style="list-style-type: none"> • Add the person who lost entitlement to Medicaid, Medi-Cal, or SCHIP 	<ul style="list-style-type: none"> • Drop coverage for yourself or any enrolled dependents • Change plans

Employment Status Events

If you experience the following event...	You may make the following change(s) within 60 days of the event...	YOU MAY NOT make these types of Changes
You become newly eligible for benefits due to change in employment status or bargaining group	<ul style="list-style-type: none"> • Enroll yourself, if applicable • Enroll your spouse/DP and other eligible dependents 	<ul style="list-style-type: none"> • Enroll, drop or change plans if your employment change does not result in you being eligible for a new set of benefits
Spouse/DP obtains health benefits in another group health plan	<ul style="list-style-type: none"> • Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage if they enroll in spouse's or DP's coverage • Drop coverage for yourself if you enroll in your spouse's/DP's coverage * Proof of coverage in the other health plan required 	<ul style="list-style-type: none"> • Change health plans. • Add any eligible dependents to your health coverage. • Enroll yourself if you are not currently enrolled
Spouse/DP loses employment, experiences a termination of their employer's contribution, or otherwise loses coverage or eligibility for health benefits in another group, individual, or exchange health plan.	<ul style="list-style-type: none"> • Enroll your spouse/DP and, if applicable, eligible dependent children in your health plan • Enroll yourself in a health plan if previously not enrolled because you were covered under your spouse/DP's plan • Change health plans * Proof of loss of other coverage is required 	<ul style="list-style-type: none"> • Drop health coverage for yourself or any other covered dependents
You or your dependents exhaust COBRA coverage under other group health plan.	<ul style="list-style-type: none"> • Enroll your spouse/DP and, if applicable, eligible dependent children in your health plan • Enroll yourself in a health plan if previously not enrolled because you were covered under a COBRA plan • Change health plans * Proof of loss of COBRA coverage is required 	<ul style="list-style-type: none"> • Drop health coverage for yourself or any other covered dependents
You lose employment or otherwise become ineligible for health benefits	<ul style="list-style-type: none"> • You must drop coverage for yourself and any enrolled Dependents because you are no longer eligible for coverage 	<ul style="list-style-type: none"> • Add any Dependents
You experience a reduction in hours (e.g. full-time to part-time) that results in a significant cost increase	<ul style="list-style-type: none"> • Drop coverage for yourself (only if there is a significant cost change and there is no other similar health plan option available) • Change health plans to a less expensive plan 	<ul style="list-style-type: none"> • No change is allowed unless there is a significant reduction of the employer subsidy for medical (not FSA) coverage. Financial hardship (including due to a pay cut or reduction in hours) does not trigger the change in cost rule.

Employment Status Events, cont.

If you experience the following event...	You may make the following change(s) within 60 days of the event...	YOU MAY NOT make these types of Changes
<p>You experience an unpaid leave (e.g. leave without pay) not covered by FMLA, CFRA etc. where the County will no longer be making a contribution</p>	<ul style="list-style-type: none"> • You may suspend coverage for yourself and dependents while on leave and reinstate coverage upon return to work if you are still eligible then 	<ul style="list-style-type: none"> • Add or Drop any dependents, change plans, or enroll if not currently enrolled
<p>You experience an increase in hours (e.g. part-time to full-time) that results in a significant cost decrease or return from an unpaid leave (e.g. leave without pay) when the County was not making a benefit contribution</p>	<ul style="list-style-type: none"> • Add coverage for yourself • Add your spouse/DP, or dependent children to your health coverage • Change health plans to a more expensive plan 	<ul style="list-style-type: none"> • No change is allowed unless there is a significant change in the employer subsidy for health (not FSA) coverage
<p>You return from Military leave</p>	<ul style="list-style-type: none"> • Prior elections at beginning of leave are reinstated unless another Change Event has occurred which permits the change 	
<p>You, your spouse, or dependents enroll in a Qualified Health Plan through a Public health Insurance Marketplace</p>	<ul style="list-style-type: none"> • Drop your spouse/DP from your health coverage • Drop your dependent children from your health coverage • Drop coverage for yourself * Proof of enrollment in Marketplace Coverage is required 	<ul style="list-style-type: none"> • Add any dependents, change plans, or enroll yourself if not currently enrolled

APPEALS PROCESS

GENERAL INFORMATION

In the event an employee believes that a request for health benefit eligibility or enrollment has been improperly denied by the County of Sonoma Human Resources Benefits Unit, they may appeal the decision within the parameters set forth in the following procedure.

TIME FRAMES

Any employee whose request for benefits is denied has the right to request a review by filing an appeal in writing directly with the HR Benefits Unit. Appeals must be submitted within 30 calendar days of the notice of denial or adverse decision. The appeal should include the basis for the appeal, as well as any supporting documentation.

If the appeal does not contain sufficient information to make a decision, the appellant will be notified in writing of the extension which will specifically describe the required information.

NOTIFICATION

Upon timely delivery of the requested information, and within 30 calendar days, the HR Benefits Unit will report its findings. Should the requested information not be received by the HR Benefits Unit within the time specified, the HR Benefits Unit will make a decision without it, in which case, the decision is final and is not eligible for a second appeal.

If the appellant disagrees with the HR Benefits Unit's decision and there is additional information that was not included in the first appeal which supports the position, a second appeal can be made to the attention of the HR Benefits Manager, whose decision will be final. Such appeals must be received within 15 calendar days of the first appeal decision notice.

Please contact the HR Benefits Unit with questions or concerns about the appeals process by calling (707) 565-2900 or email hr.benefits@sonomacounty.gov.

CONTACT INFORMATION AND RESOURCES

At the County of Sonoma, we're committed to helping our employees, retirees, and their families enjoy optimal health. That's why we've teamed up with community wellness partners to bring you a range of useful programs and wellness tools.

CARECOUNSEL

Advocating for You and With You. Navigating the complex world of health benefits can be a challenge, leaving you questioning if you have made the right choices for you and your

family's best health. CareCounsel's health advocacy program is a confidential health advocacy benefit sponsored by the County that can help you understand and effectively navigate your health benefits. This service is available to County employees, retirees and their family members who are enrolled in County sponsored medical, dental and/or vision plans.



CareCounsel offers high touch and customized service backed by experience and depth. Here are just a few of the things CareCounsel can help you with:

- Compare health plan options and the differences between plan coverage
- Benefits education and assistance for all types of health plans (medical, dental, etc.)
- Getting the most of your healthcare dollars
- Locate network doctors, hospitals and ancillary services
- Obtaining second opinions
- Troubleshooting medical claims/bills
- Provide support for grievances and appeals
- Navigating Medicare (when you turn 65 and ongoing)
- Helping you become a more proactive health consumer
- Access to the Stanford Health Library
- Stanford educational webinars and community education sessions
- Connecting you with expert healthcare resources



You can reach CareCounsel at (888) 227-3334 or submit secure web portal request at www.carecounsel.com or email staff@carecounsel.com. Member Care Specialists are available 6:30 a.m. to 5:00 p.m. PST Monday - Friday. CareCounsel is a wholly owned subsidiary of Stanford Health Care.

Keep CareCounsel at your fingertips; scan the QR code and save their contact information:



1. Focus smart phone camera on QR code
2. Select "Add 'CareCounsel'" to contacts from the banner at the top of the screen
3. Select "Save" in the upper, right-hand corner of the contact information
4. Call, email, visit webpage or share the contact with your dependents via contact info

CUSTOMER SERVICE SUPPORT

Visit the insurance company websites for additional resources. Contact the Human Resources Benefits Unit with questions related to your eligibility, coverage, and Annual Enrollment Period.

E-mail: hr.benefits@sonomacounty.gov

Phone: (707) 565-2900

Internet: <https://sonomacounty.gov/benefits>

Take note: Staffing resources are limited. When calling, leave one clear message rather than multiple messages. Your call will be returned as soon as possible. Please do not call to confirm receipt of your election. Print a copy of your election as proof of completion.

Contact your health plan carriers with questions related to your benefits coverage, to find network providers, preauthorize care as required, and confirm your residence is within the plans' service areas.

Plan	Phone	Website
County Health Plans (PPO & EPO) Administered by Anthem Blue Cross	Member Services (800) 227-3771 24/7 Nurseline (800) 700-9186	www.anthem.com/ca
RX Benefits County Health Plans' prescription drug provider	(800) 334-8134	member.rxbenefits.com
Kaiser Permanente	(800) 464-4000	www.my.kp.org/sonomacounty www.kp.org
Sutter Health Plan	(855) 315-5800	https://www.sutterhealthplan.org/sonoma-county
Western Health Advantage	(888) 563-2250	https://advantage.western-health.com/county-of-sonoma
Delta Dental	(800) 765-6003	www.deltadentalins.com
Vision Service Plan (VSP)	(800) 877-7195	www.vsp.com
Hartford Life Insurance	Claims (888) 563-1124 Conversion/Portability (877) 320-0484	
County Wellness Program	(707) 565-2900	https://sonomacounty.gov/wellness-resources
TASC COBRA, HRA and FSA	(877) 401-9807	tasconline.com
Sonoma County HIPAA Privacy Practices	(707) 565-5703	https://sonomacounty.gov/health-and-human-services/health-services/about-us/notice-of-privacy-practices

For more information regarding medical plan coverages, please review the Summary of Benefits and Coverage (SBC). The SBC's be found on the County website at:

<https://sonomacounty.gov/benefit-forms-plan-documents-and-important-information>.

REQUIRED NOTICES

Medicare Notice of Creditable Coverage Reminder

If you or your eligible dependents are currently Medicare eligible, or will become Medicare eligible during the next 12 months, you need to be sure that you understand whether the prescription drug coverage that you elect under the County-sponsored medical plans is or is not creditable with (as valuable as) Medicare's prescription drug coverage.

To find out whether the prescription drug coverage under the medical plan options offered by the County are or are not creditable you should review the Plan's Medicare Part D Notice of Creditable Coverage below.

IMPORTANT NOTICE FROM THE COUNTY OF SONOMA ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE - YOUR MEDICARE PART D NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the County of Sonoma 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 Sonoma has determined that the prescription drug coverage offered by the County sponsored medical plans are, 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?

As an employee, if you decide to join a Medicare drug plan, your current active employee County of Sonoma coverage will not be affected. As a retiree, if you decide to join a Medicare drug plan, your current retiree County of Sonoma coverage will be affected. For further information on how your coverage will be affected, please contact your benefit office or CareCounsel at the number below.

If you do decide to join a Medicare drug plan and drop your current County of Sonoma coverage, be aware that you and your dependents will not be able to get this coverage back.

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 the County of Sonoma 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...

See contact information 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 the County of Sonoma 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 www.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 www.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: March 1, 2026
Name of Entity/Sender: County of Sonoma
Contact—Position/Office: Human Resources Benefits Unit
Address: 575 Administration Dr., Suite 116B, Santa Rosa, CA 95403
Phone Number: (707) 565-2900 or hr.benefits@sonomacounty.gov

Health Insurance Counseling and Advocacy Program (HICAP): (800) 434-0222
Healthcare Advocacy, CareCounsel: (888) 227-3334

WOMEN’S HEALTH AND CANCER RIGHTS ACT NOTICE

The Women’s Health and Cancer Rights Act of 1998 (WHCRA) requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies.

Because the group health plans offered by the County provide coverage for mastectomies, WHCRA applies to your plan. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthesis; and
4. Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be subject to the same annual deductible, coinsurance and/or copay provisions otherwise applicable to medical and surgical services under the policy/plan.

If you have questions about this Notice, contact HR Benefits Unit at (707) 565-2900 or hr.benefits@sonomacounty.gov.

NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT NOTICE

Hospital Length of Stay for Childbirth: Under federal law, group health plans, like this Plan, (including medical plans sponsored by the County) generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not, under federal law, require that a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of stay longer than 48 hours for vaginal birth or 96 hours for C-section, contact your plan provider to precertify the extended stay. If you have questions about this Notice, contact HR Benefits Unit at (707) 565-2900 or hr.benefits@sonomacounty.gov.

SPECIAL ENROLLMENT EVENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in a County-sponsored plan if you or your dependents lose eligibility for that other coverage (or if your employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. You and your dependents may also enroll in this plan if you (or your dependents):

- Have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends.
- Become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact HR Benefits Unit at (707) 565-2900 or hr.benefits@sonomacounty.gov.

PRIVACY NOTICE REMINDER

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires health plans to comply with privacy rules. These rules are intended to protect your personal health information from being inappropriately used and disclosed. The rules also give you additional rights concerning control of your own healthcare information.

This Plan's HIPAA Privacy Notice explains how the group health plan uses and discloses your personal health information. You are provided a copy of this Notice when you enroll in a health Plan. You can get another copy of this Notice from the County of Sonoma Privacy Officer at (707) 565-5703 or <https://sonomacounty.gov/health-and-human-services/health-services/about-us/notice-of-privacy-practices>.

CAUTION: IF YOU DECLINE MEDICAL PLAN COVERAGE OFFERED THROUGH THE COUNTY OF SONOMA

If you are in a benefits-eligible position and choose not to be covered by one of County of Sonoma's medical plan options, remember that you must maintain medical plan coverage elsewhere or you can purchase health insurance through a Marketplace (www.healthcare.gov), typically at the Marketplace annual enrollment in the fall each year.

Note that, if you are a resident in certain states, including California, you may be subject to a state income tax penalty if you fail to maintain medical plan coverage that meets that state's minimum coverage requirements. Consult with your own state's insurance department for information on whether your state has adopted or will be adopting a state individual Mandate penalty.

If you choose to not be covered by a medical plan sponsored by County of Sonoma at this enrollment time, your next opportunity to enroll for County of Sonoma's medical plan coverage is at the next annual open enrollment time, unless you have a mid-year change event that allows you to add coverage in the middle of County of Sonoma's plan year.

IRS FORM 1095C

Under the Affordable Care Act, employers (and in some cases insurance companies) are required to provide full-time employees, as well as other employees enrolled in a medical plan, with IRS Form 1095C. It will be provided to you on or by March 1, 2026.

For each month of 2025 that you were enrolled in a medical plan, this 1095C form documents that you (and any enrolled family members) met the federal requirement to have “minimum essential coverage or MEC,” meaning group medical plan coverage.

If you receive a 1095C form, you do not need to attach the form to your personal income tax return or wait to receive the form before filling your tax return. If you receive a form this year, you should keep it in a safe place with your other tax records because you may need to produce it if requested by the IRS. (For large employers, a copy of the form 1095C will also be provided to the IRS.)

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT

Designation of a Primary Care Provider (PCP): The Kaiser, Sutter, and Western Health Advantage medical plan generally requires the designation of a primary care provider (PCP). You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, the health insurance company designates one for you. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the health insurance company at the number provided on page 53.

Direct Access to OB/GYN Providers: You do not need prior authorization (pre-approval) from Kaiser, Sutter, Western Health Advantage, Anthem or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological (OB/GYN) care from an in-network health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health plan carrier at the phone number or website address provided on page 53.

KEEP THE COUNTY NOTIFIED OF CHANGES IN ELIGIBILITY FOR BENEFITS

YOU ARE REQUIRED TO PROVIDE TIMELY NOTICE

You or your Dependents must promptly furnish to the County's HR Benefits Unit information regarding change of name, address, marriage, divorce or legal separation, change in Domestic Partnership status, death of any covered family member, birth or change in status of a Dependent Child, Medicare enrollment or dis-enrollment, an individual meets the termination provisions of the Plan, or the existence of other coverage. Proof of legal documentation will be required for certain changes.

Notify the Plan preferably within 31 days, but no later than 60 days, after any of the above noted events.

Failure to give the County a timely notice of the above noted events may:

- Cause you, your Spouse and/or Dependent Child(ren) to lose the right to obtain COBRA Continuation Coverage,
 - Cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability,
 - Cause claims to not be able to be considered for payment until eligibility issues have been resolved,
 - Result in your liability to repay the Plan if any benefits are paid to an ineligible person. The Plan has the right to offset the amounts paid against the participant's future [medical, dental, and/or vision] benefits.
-

In accordance with the requirements in the Affordable Care Act, your employer will not retroactively cancel coverage (a rescission) except when premiums are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. Keeping an ineligible dependent enrolled (for example, an ex-spouse, overage dependent child, etc.) is considered fraud. If you have questions about eligibility contact HR Benefits Unit at (707) 565-2900 or hr.benefits@sonomacounty.gov.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING

PROTECTIONS:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval for services in advance (also known as “prior authorization”).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you have been wrongly billed and/or have questions about rights under federal law, contact the Centers for Medicare & Medicaid Services at NonFed@cms.hhs.gov.

Visit <https://www.cms.gov/nosurprises> for more information about your rights under federal law.

FAMILY CARE & MEDICAL LEAVE & PREGNANCY DISABILITY LEAVE



Civil Rights
Department
STATE OF CALIFORNIA



Under California law, an employee may have the right to take job-protected leave to care for their own serious health condition or a family member with a serious health condition, or to bond with a new child (via birth, adoption, or foster care). California law also requires employers to provide job-protected leave and accommodations to employees who are disabled by pregnancy, childbirth, or a related medical condition.

Under the California Family Rights Act of 1993 (CFRA), many employees have the right to take job-protected leave, which is leave that will allow them to return to their job or a similar job after their leave ends. This leave may be up to 12 work weeks in a 12-month period for:

- The employee's own serious health condition
- The serious health condition of a child, spouse, domestic partner, parent, parent-in-law, grandparent, grandchild, sibling, or someone else with a blood or family-like relationship with the employee ("designated person")
- The birth, adoption, or foster care placement of a child

If an employee takes leave for their own or a family member's serious health condition, leave may be taken on an intermittent or reduced work schedule when medically necessary, among other circumstances.

Eligibility. To be eligible for CFRA leave, an employee must have more than 12 months of service with their employer, have worked at least 1,250 hours in the 12-month period before the date they want to begin their leave, and their employer must have five or more employees.

Pay and Benefits During Leave. While the law guarantees only unpaid leave, some employers pay their employees during CFRA leave. In addition, employees may choose (or employers may require) use of accrued paid leave while taking CFRA leave in certain circumstances. Employees on CFRA leave may also be eligible for benefits administered by the Employment Development Department, including Paid Family Leave. For more information, visit bit.ly/EDD-PFL.

Taking CFRA leave may impact certain employee benefits and an employee's seniority date. If employees want more information regarding eligibility for leave and/or the impact of the leave on seniority and benefits, they should contact their employer.

Pregnancy Disability Leave. When an employee is disabled by pregnancy, childbirth, or a related medical condition, the employee is entitled to take a pregnancy disability leave of up to four months, depending on their period(s) of actual disability. If the employee is also eligible for CFRA leave, they have the right to take both pregnancy disability leave and CFRA leave related to the birth of their child.

Reinstatement. Both CFRA leave and pregnancy disability leave guarantee reinstatement to the same position or, in certain instances, a comparable position at the end of the leave, subject to any defense allowed under the law.

Notice. When possible, employees must provide 30 days' advance notice before taking leave for foreseeable event, such as the expected birth of a child or a planned medical procedure. For unforeseeable events, employees should notify their employers, at least verbally, as soon as they learn of the need for the leave. Failing to provide notice is grounds for, and may result in, deferral of the requested leave until the employee complies with this notice policy.

Certification. Employers may require certification from an employee's health care provider before allowing leave for pregnancy disability or for the employee's own serious health condition. Employers may also require certification from the health care provider of the employee's family member, including a designated person, who has a serious health condition, before granting leave to take care of that family member.

Want to learn more?

Visit: calcivilrights.ca.gov/family-medical-pregnancy-leave/

If you have been subjected to discrimination, harassment, or retaliation at work, or have been improperly denied protected leave, file a complaint with the Civil Rights Department (CRD).

TO FILE A COMPLAINT

Civil Rights Department

calcivilrights.ca.gov/complaintprocess

Toll Free: 800.884.1684 / TTY: 800.700.2320

California Relay Service (711)

Have a disability that requires a reasonable accommodation? CRD can assist you with your complaint.



YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: <https://www.dol.gov/agencies/vets/programs/userra/poster> Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at <https://www.dol.gov/agencies/vets/>. An interactive online USERRA Advisor can be viewed at <https://webapps.dol.gov/elaws/vets/userra>
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.



U.S. Department of Labor
1-866-487-2365



U.S. Department of Justice



Office of Special Counsel



1-800-336-4590

Publication Date — May 2022

EMPLOYER NOTICE ABOUT THE HEALTH INSURANCE MARKETPLACE

As your employer, the County should distribute a notice to new employees when they are first hired. The notice is at least two pages long. To help you recognize the notice, here is a snapshot of the first page of the Notice:



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.^{1,2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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 January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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

<p>COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)</p>	<p>FLORIDA – Medicaid</p>
<p>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</p>	<p>Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268</p>
<p>GEORGIA – Medicaid</p>	<p>INDIANA – Medicaid</p>
<p>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</p>	<p>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: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>
<p>IOWA – Medicaid and CHIP (Hawki)</p>	<p>KANSAS – Medicaid</p>
<p>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</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
<p>KENTUCKY – Medicaid</p>	<p>LOUISIANA – Medicaid</p>
<p>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: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084</p>

<p align="center">MAINE – Medicaid</p> <p>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: 1-800-977-6740 TTY: Maine relay 711</p>	<p align="center">MASSACHUSETTS – Medicaid and CHIP</p> <p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
<p align="center">MINNESOTA – Medicaid</p> <p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p align="center">MISSOURI – Medicaid</p> <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
<p align="center">MONTANA – Medicaid</p> <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p align="center">NEBRASKA – Medicaid</p> <p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
<p align="center">NEVADA – Medicaid</p> <p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p align="center">NEW HAMPSHIRE – Medicaid</p> <p>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</p>
<p align="center">NEW JERSEY – Medicaid and CHIP</p> <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)</p>	<p align="center">NEW YORK – Medicaid</p> <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
<p align="center">NORTH CAROLINA – Medicaid</p> <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p align="center">NORTH DAKOTA – Medicaid</p> <p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>
<p align="center">OKLAHOMA – Medicaid and CHIP</p> <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p align="center">OREGON – Medicaid</p> <p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>

<p align="center">PENNSYLVANIA – Medicaid and CHIP</p> <p>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)</p>	<p align="center">RHODE ISLAND – Medicaid and CHIP</p> <p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItte Share Line)</p>
<p align="center">SOUTH CAROLINA – Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p align="center">SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>
<p align="center">TEXAS – Medicaid</p> <p>Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493</p>	<p align="center">UTAH – Medicaid and CHIP</p> <p>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/</p>
<p align="center">VERMONT– Medicaid</p> <p>Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427</p>	<p align="center">VIRGINIA – Medicaid and CHIP</p> <p>Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924</p>
<p align="center">WASHINGTON – Medicaid</p> <p>Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022</p>	<p align="center">WEST VIRGINIA – Medicaid and CHIP</p> <p>Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
<p align="center">WISCONSIN – Medicaid and CHIP</p> <p>Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002</p>	<p align="center">WYOMING – Medicaid</p> <p>Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269</p>

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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 3/31/2026)

HR BENEFITS UNIT

Have questions? Contact the HR Benefits Unit at hr.benefits@sonomacounty.gov or call us at (707) 565-2900. Calls will be returned within 48 hours. Many questions can be answered by viewing our website at <https://sonomacounty.gov/benefits>.

NEED HELP SELECTING PLANS?

CareCounsel is your personal, confidential, healthcare advocate available to assistance with questions regarding health plan benefits and choosing a plan that is best for you.

Contact **CareCounsel** at (888) 227-3334 Monday-Friday 6:30 a.m. - 5:00 p.m.

www.CareCounsel.com



23020500
COUNTY OF SONOMA
HUMAN RESOURCES DEPARTMENT - BENEFITS UNIT
575 ADMINISTRATION DRIVE, SUITE 116B
SANTA ROSA, CA 95403

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