EMPLOYEE BENEFITS *Guide*

2026

NEVADA COUNTY
CALIFORNIA

Employee Benefits Guide 2026

General Information

Core Benefits

Other Benefits

Compliance Notices

Miscellaneous

Click this icon in your benefits guide to watch a video explaining the associated topic.

If you (and/or your dependents) have Medicare or you will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 72 for more details.

The information in this brochure is a general outline of the benefits offered under Nevada County's benefits program. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

Introduction

As a Nevada County (The County) employee, you and your eligible family members are entitled to a number of benefits. This benefits guide contains information on all of the benefits you are entitled to as an employee of the County. Benefits will begin on the first day of the month following date of employment.

In order to activate your benefits, complete and submit your elections for the following benefits during your 60-day period of initial eligibility for Medical and 30-day period for all other benefits:

Elections subject to Qualifying Event (hire, life change, employment change):

- Medical
- Dental
- Vision
- Cash-in-lieu
  - Cash-in-Lieu is for waiving medical insurance ($300/month for full-time employees)
  - If you waive medical insurance, you can still participate in dental and vision insurance
  - Evidence of participation in another group plan that provides minimal essential coverage is required
  - This is NOT auto-renewing - election must be made every open enrollment period
- Flexible Spending Account for Medical and Dependent Care Expenses (IRS Section 125)
- Voluntary Term Life Insurance (for employee)
- Voluntary Term Life Insurance (for eligible dependents, spouse, children to age 26)
- Building Blocks-Colonial Supplemental Benefits (Accident, Cancer, Critical Illness, Medical Bridge & Life Insurance)

Truckee Rural Health Subsidy

Available to Truckee-area employees only, because there is no HMO plan available to those employees.

- **Employee Only:** Up to $1,500 per year
- **Employee+Dependents:** Up to $3,000 per year

Benefit Choices

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

While we've made every effort to make sure that this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

Who Can You Cover?

Who is Eligible?

In general, full-time and part-time employees working 20 or more hours per week are eligible for the benefits outlined in this overview. You can enroll the following family members in our medical, dental and vision plans.

Spouse

Your spouse (person who you are legally married to under state law, including a same-sex spouse.)

Registered Domestic Partner

- You may add your registered domestic partner to your health plan within 60 days of registration of the domestic partnership. The coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.
- To add a domestic partner to your health plan, you must register your domestic partnership through the California Secretary of State's Office or equivalent office from another state. Upon registration, that office will provide you with a Declaration of Domestic Partnership, the domestic partner's Social Security number, and a copy of their Medicare card (if applicable).
- Same sex domestic partnerships between persons who are both at least age 18 and certain opposite sex domestic partnerships (one partner must be 62 years of age or older and the other partner at least 18 years of age) are eligible to register with the Secretary of State. For more information about domestic partnership registration, visit the Secretary of State's website at www.sos.ca.gov.

Children

Natural-born, adopted, domestic partners, and stepchildren who are under age 26 may be added to your health plan, as outlined below:

- Newborn children should be added within 60 days of birth. Coverage is effective from the date of birth.
- Newly adopted children should be added within 60 days of physical custody. Coverage is effective from the date physical custody is obtained.
- Stepchildren or a domestic partner's children under age 26 can be added within 60 days after the date of your marriage or registration of your domestic partnership. The coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

Disabled Children Over Age 26

A child age 26 and over who is incapable of self-support because of a mental or physical condition may be eligible for enrollment. The disability must have existed prior to reaching age 26 and continuously since age 26, as certified by a licensed physician. You are required to complete and submit the Member Questionnaire for the CalPERS Disabled Dependent Benefit form, and the physician must complete and submit a Medical Report for the CalPERS Disabled Dependent Benefit form for CalPERS approval. The initial certification of the Disabled Dependent must occur during one of the following two eligibility periods (whichever applies):

- Within 60 days before and ending 60 days after the child's 26th birthday (member and dependent currently enrolled), or
- Within 60 days of a newly eligible employee's initial enrollment in the CalPERS Health Program.

Upon certification of eligibility, the dependent's coverage must be continuous and without lapse. You will be required to submit an updated questionnaire and medical report for re-certification periodically, upon request.

Note: if the disabled child has a Social Security-approved disability, you must provide CalPERS with a copy of his or her Medicare card. Please refer to the Summary Plan Description for complete details on how benefits eligibility is determined.

Who Can You Cover? (continued)

Dependents in a Parent-Child Relationship

A child other than an adopted, step, or recognized natural child up to age 26 may be added to your health plan if you have assumed parental status, or assumed the parental duties as certified at the time of enrollment of the child, and annually thereafter up to the age of 26.

You have 60 days from the date you obtained custody of the child to enroll him or her on your health plan. Prior to enrollment of a dependent who is in a parent-child relationship, you must complete and submit an Affidavit of Parent-Child Relationship. You will be required to provide supporting documentation as indicated on the Affidavit of Parent-Child Relationship. Coverage will become effective the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

For dependents under the age of 19, the annual recertification will require a copy of the first page of your income tax return from the previous year listing the child as a tax dependent. In lieu of a tax return, for a time not to exceed one tax filing year, you may submit other documents that substantiate the child's financial dependence.

For dependents from age 19 up to age 26, the annual re-certification requires: a copy of the first page of your income tax return from the previous tax year listing he child as a tax dependent; or documents that substantiate that the child is financially dependent, provided that the child: either lives with you for more than 50 percent of the time, or is a full-time student; and, is dependent upon you for more than 50 percent of his or her support.

Who is Not Eligible?

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

- Former spouses/former registered domestic partner
- Children age 26 and older
- Disabled children over age 26 who were never enrolled or who were deleted from coverage
- Children of a former spouse/former registered domestic partner
- Parents, grandparents, and siblings
- Any individual who is covered as an employee of Nevada County cannot also be covered as a dependent in any CalPERS medical plan
- Employees who work less than 20 hours per week, temporary employees, contract employees, or employees residing outside the United States

Enrollment Options

When Can I Enroll?

You have 60 days from the date of your initial appointment to enroll, or decline to enroll, yourself or yourself and all eligible family members in a health plan. The effective date is the first day of the month following the date your Health Benefits Officer receives the Health Benefits Plan Enrollment form.

When you enroll, you must enroll yourself or yourself and all eligible family members, unless the family member is:

- Covered under another health plan
- A spouse not living in your household
- A child who has attained the age of 18
- A member of the armed forces

Open enrollment for current benefit eligible employees is held each fall, and the changes become effective the following January 1. Open enrollment is the one time each year that employees can make changes to their benefit elections without a qualifying life event.

Enrollment Instructions

When you are hired, you receive this Employee Benefits Guide describing your various benefit options and will receive log on information for Benefit Bridge. For more information on making your elections in the Benefit Bridge System, please refer to the Benefit Bridge Frequently Asked Questions starting on page 6.

Here are some basic guidelines you need to keep in mind when going over these choices:

1. Review the available medical plans in this Guide and on BenefitBridge to determine which plan works best for your health and financial needs.
2. Be sure to search your physical address zip code using the following link to determine which CalPERS medical plans you are eligible to enroll in.
   https://www.calpers.ca.gov/page/active-members/health-benefits/plans-and-rates/zip-search
3. Determine your life insurance needs and decide if you wish to buy additional coverage above what is provided.
4. Review additional voluntary benefits to determine whether they meet your needs.
5. If you have medical coverage through another source, such as a spouse, you may want to consider the benefit waiver option. Proof of other group coverage will be required in order to qualify.

Change in Beneficiaries

Certain events in your life such as marriage, divorce, or a death in the family can affect who you name as your designated beneficiary for certain benefits. You may change your beneficiary(ies) at any time. Complete beneficiary designations on BenefitBridge at any time.

Changes in Enrollment

Qualifying Events

You may experience certain events during the plan year that would allow you to change you or your dependent's medical coverage. If any of the following events occur, you must change your benefit coverage within 60 days of the event:

- Change in your legal marital or domestic partner status, including marriage, death of your spouse/domestic partner, divorce, legal separation or annulment.
- Change in the number of your dependents, including birth, adoption, placement for adoption or death of a dependent.
- Change in your employment status, including termination or commencement of employment for you, your spouse, your domestic partner or your dependent.
- Change in work schedule for you or your spouse/domestic partner, including an increase or decrease in the number of hours of employment, a switch between full-time and part-time status, a strike, lockout or commencement of or return from an unpaid leave of absence.
- Your dependent satisfies or no longer meets the eligibility requirements for dependents.
- A change in the place of residence or work site for you or your spouse/domestic partner (this move must affect your coverage options).
- You, your spouse/domestic partner or your dependents lose COBRA coverage.
- You, your spouse/domestic partner or your dependents enroll for Medicare or Medicaid or lose coverage under Medicare or Medicaid.
- A significant change in benefit or cost of coverage for you or your spouse/domestic partner.
- Your spouse/domestic partner's employer provides the opportunity to enroll or change benefits during an open enrollment period.

BenefitBridge Frequently Asked Questions

1. What is BenefitBridge?

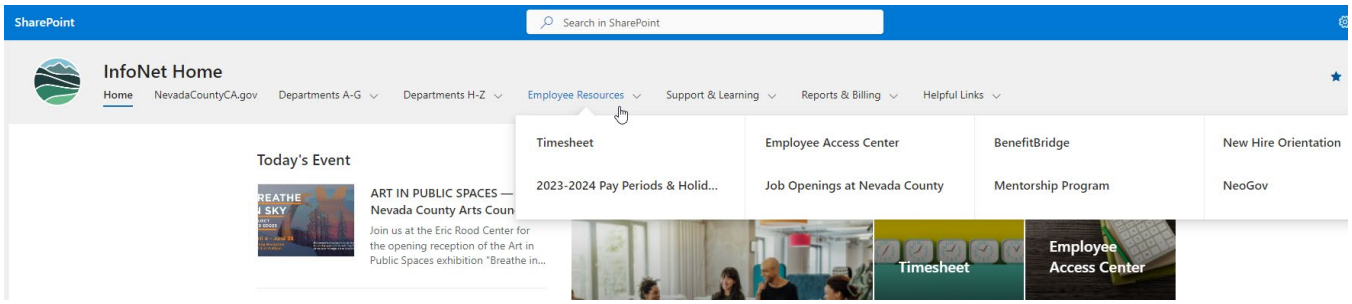
BenefitBridge is a secure, web-based portal that employers and their employees access for benefits information and enrollment. BenefitBridge houses employee enrollments, providing employees with self- service access to benefit information and a single resource for eligibility.

2. What can I do on BenefitBridge?

- View Current Plan Year Benefits
- Compare Plan Options
- Enroll in Benefits
- View Resource Center containing Health Insurance Basics, Medicare information, a Glossary, and Media Resources
- Manage Life Events, e.g., Add or Remove Dependents
- Add or Remove Beneficiaries
- View Message Center
- Update Account Information

3. How do I log on to BenefitBridge?

- Logging in to BenefitBridge is EASY, you can simply click on the BenefitBridge link on SharePoint. Your login is connected to your Microsoft single sign-on.



BenefitBridge Frequently Asked Questions (continued)

4. Who do I contact for assistance?

- Trouble logging in or navigating through BenefitBridge?
  - Call BenefitBridge Customer Care, Monday – Friday 8:00 AM – 5:00 PM PST, 1-800-814-1862 or via email at benefitbridge@keenan.com
- Benefit or premium related questions?
  - Contact your benefits or human resources department or the specific health plan carrier

5. Can I use Apple devices?

Yes, BenefitBridge works with all browsers including Internet Explorer, Chrome, and Safari.

6. Is there a mobile app available?

Yes, there is! Here's what you can currently do with the app:

- View your benefit plan information and covered dependents
- Store an image of your medical ID cards and provider information for handy access
- Find a pharmacy near your current location (turn on "Location Services" when prompted)

To download the app, go to the Apple Store or Google Play; search for and select "BenefitBridge." Once the app has been installed, all you need to do is tap the BenefitBridge icon and type in your BenefitBridge user ID and password. Once the setup is complete, the Apple Touch ID (if supported on your device) can be activated, saving you time in entering your login credentials.

7. Internet Browsers

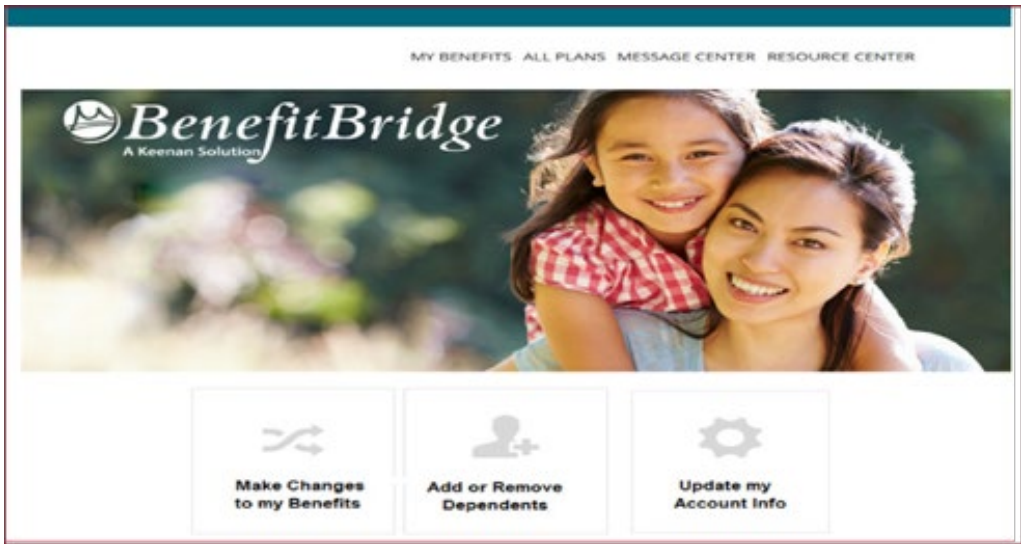
Users are no longer limited to Internet Explorer (IE). IE is no longer the leading browser; its usage is under 8% and continues to decline. Consumers are using Chrome more frequently and as a result, IE is being phased out as a supported browser by many online vendors. BenefitBridge still supports IE, however, many voluntary product system integrations do not. This may cause error messages and system issues during online enrollments; we suggest upgrading your browser to Chrome to avoid browser compatibility issues.

If you are experiencing an issue with BenefitBridge you may contact BenefitBridge Customer Care for assistance.

8. Enrolling in Benefits?

Log in to BenefitBridge and access your enrollment via the Make Changes to my Benefits button.

BenefitBridge Frequently Asked Questions (continued)



I will enroll or am enrolled in an HMO (Health Maintenance Organization) plan and require a PCP (Primary Care Physician) selection. How do I choose a PCP?

During your initial enrollment selecting an HMO plan, BenefitBridge will provide instructions during the enrollment process, directing you to the specific carrier's provider search site. At the provider search screen, once you have located your PCP, you should note the provider number as you will need to add that to BenefitBridge. After the initial enrollment and selection of the PCP, any future PCP changes may be done directly with the health plan carrier. BenefitBridge only collects this information during the initial, first-time enrollment.

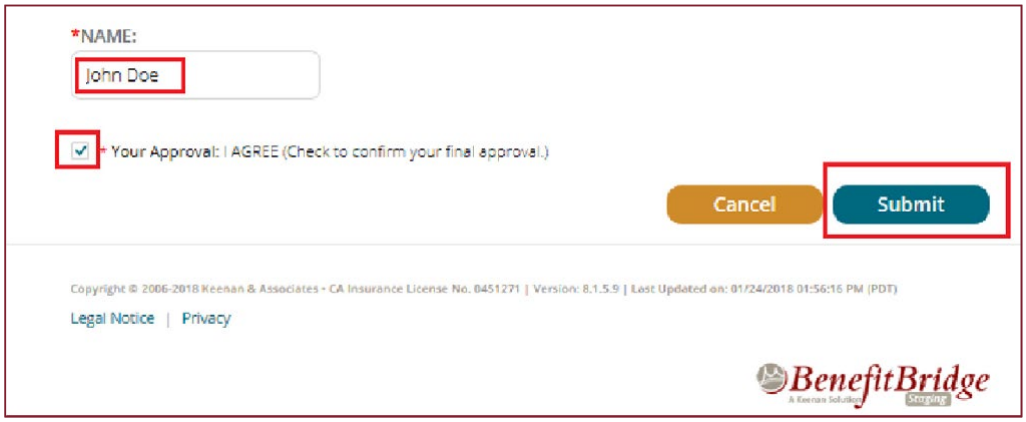
Important Note: When searching for a PCP, please pay attention to whether the PCP is accepting new patients. Unless you are an Existing patient, your selection must be an open practice. BenefitBridge does have an Existing patient indicator.

How will I know my enrollment selections were updated in BenefitBridge and with my employer?

As you navigate through BenefitBridge, each screen requiring action will have a Continue button at the bottom. If you must stop at any point during the enrollment process, you can log back in to complete your enrollment. When you log in again, the previous elections will be saved; however, you may need to maneuver to the location where you left off to continue and confirm your enrollment.

At the end of the enrollment process, there are two Summary screens to review. The first screen allows you to review your selections prior to signing off on your choices. The screenshot below is an example of the first Summary screen.

The second Summary screen provides the employee acknowledgement language, a summary of elections, medical arbitration language (if appropriate), and the electronic signature/final approval boxes. Once you review your elections, you must scroll down to the bottom of the screen, type in your name, check the "Your Approval" box and select the Submit button to ensure your enrollment selections are delivered to your employer.

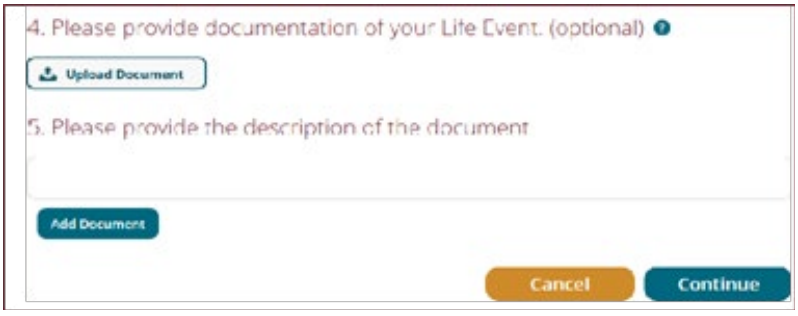


A pdf copy of your enrollment summary will be available for you to download and save for your records. You can always log in to BenefitBridge and retrieve a copy of your enrollment summary from the Message Center.

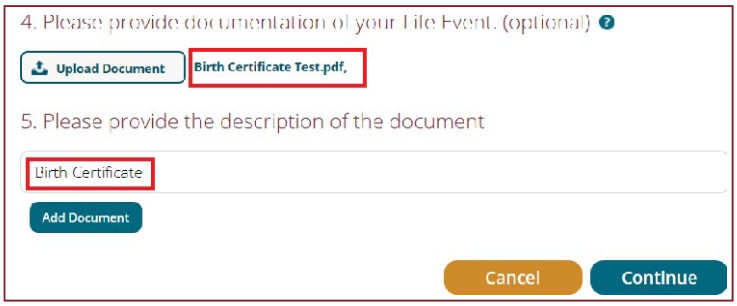
Should you wish to change any choice, you can log back in to BenefitBridge and click on the appropriate tab on the left side of the screen to navigate to the specific benefit option you wish to change. You may click continue through the balance of the screens to the Summary screens, then enter your electronic signature and once again select Submit to confirm your changes.

How can I provide the required documents to my employer for a life event?

- If your employer has elected to utilize the Upload Document feature in BenefitBridge:
  - For New Hire/Open Enrollment elections, you can add a document on the Dependent screen and/or the Summary screen.
  - For a qualifying Life Event (marriage, birth/adoption, divorce, etc.), you can add a document on the "Specify Your Life Event" screen and/or on the Summary screen.
- Click on the Upload Document button
- Browse the hard drive for the document and click Open (this may appear differently, depending on the browser used):



- Once the file has been uploaded, the screen will display the file name and the description:



- Click on the appropriate action button to add a document or to Continue to the next screen.
- If your employer has not elected to utilize the Upload Document feature in BenefitBridge:
  - It is your responsibility to provide your employer with any necessary documentation via email, regular mail or personal delivery.

9. Uploading Supporting Documents - Mandatory

When adding a new dependent, i.e., spouse, child, domestic partner, your employer may require you to upload supporting documentation during the enrollment process (as a new hire, life event or open enrollment). If documentation is required, you will see the following pop-up window appear after the new dependent information has been entered:

You will not be allowed to continue with the enrollment until this requirement is met.

10. **NEW** Current Benefit Summary Information

(Confirm with your employer if this option is available).

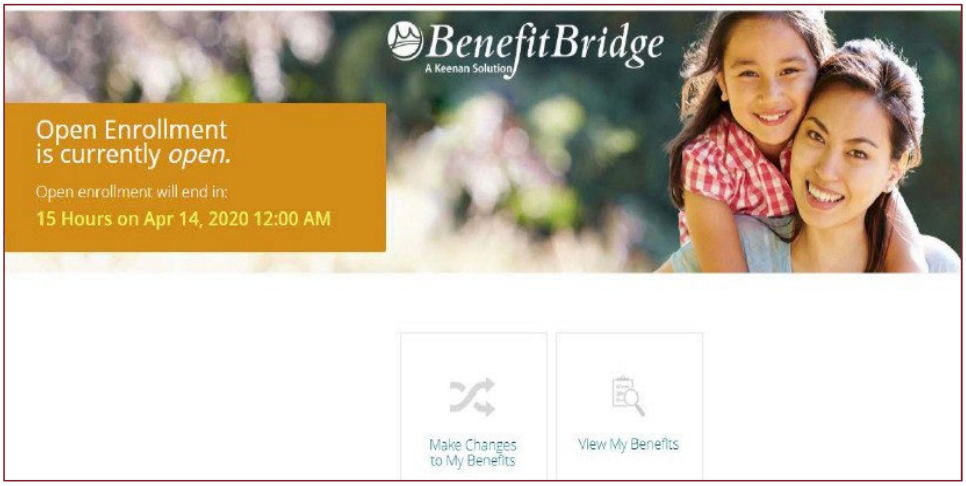
Employees can now view and/or print their **current** Benefit Summary from their Home Page during open enrollment or throughout the year by clicking on the **View My Benefits** Button.

1. On the Home tab, click View My Benefits
2. Scroll to the bottom of the screen and click the Print button.

11. How do I change my beneficiary?

If you want to update your beneficiary, log in to BenefitBridge following the instructions above and click on Make Changes to My Benefits.

- Select the appropriate life benefit
- Select Add/Change Beneficiaries and Distribution plus sign (+)

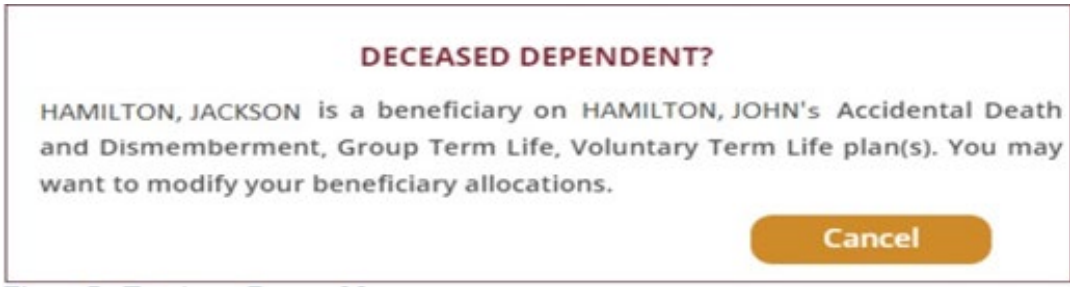


- Update as needed

You can also update your beneficiary during your district's annual open enrollment period. When adding/changing beneficiaries, you can now choose Charity/Organization as a beneficiary type.

12. **NEW** Beneficiary Designation Message

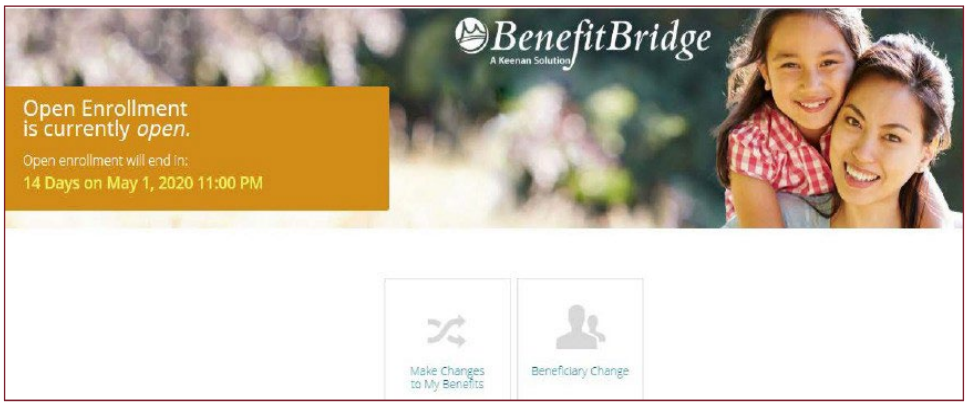
When a dependent (spouse, Ex-spouse, Domestic Partner, etc.) is marked as Deceased by the employee through an enrollment, a message will pop up with a reminder to change beneficiary designation, if desired.



13. **NEW** Beneficiary Change Button

(Confirm with your employer if this option is available).

During Open Enrollment, if you only want to update or change your beneficiary(ies) in BenefitBridge, you can bypass the Open Enrollment button and select the **Beneficiary Change Button**.



Medical – CalPERS

Direct Plan questions to CalPERS

Website: my.calpers.ca.gov

Customer Service: 888-225-7377

Contract Number: 6361598907

The County offers various medical plan options through CalPERS. These plans are made up of Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs).

Additional CalPERS Benefits and Information

The California Public Employees' Pension Reform Act (PEPRA), which took effect in January 2013, changes the way CalPERS retirement and health benefits are applied, and places compensation limits on members. The greatest impact is felt by new CalPERS members.

As defined by PEPRA, a new member includes:

- A member who joined CalPERS prior to January 1, 2013, who, on or after January 1, 2013, is hired by a different CalPERS employer following a break in service of more than six months.
- A new hire who joined CalPERS for the first time on or after January 1, 2013, and **who has no prior membership** in another California public retirement system.
- A new hire who joins CalPERS for the first time on or after January 1, 2013, and who was a member of another California public retirement system prior to that date, but **who is not subject to reciprocity** upon joining CalPERS.

All members who don't fall into the definitions above are considered classic members. Classic members will retain the existing benefit enrollment levels for future service with the same employer.

Additional Benefits through CalPERS

- Lump Sum
- Special Power of Attorney
- Name a Beneficiary

Health Maintenance Organizations (HMOs)

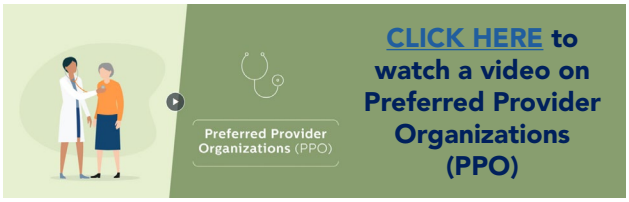
HMOs allow you to receive comprehensive coverage at set prices called copays.

- **Doctors/Other Medical Care Providers –** You can only use doctors, hospitals, and pharmacies that participate in the HMO network. Doctors who participate in the HMO network are called in-network providers. There is no coverage if you go to out-of-network providers, except for emergency services.
- **Annual Deductible –** You don't need to pay an annual deductible before the plan begins to pay for a portion of covered medical services.
- **Copays –** When you receive medical care, you pay a set dollar amount called a copay.
- **Annual Out-of-Pocket Maximum –** The HMO plans include an annual out-of-pocket maximum. This is the maximum amount you must pay out of your own pocket for copays during the plan year. Once you reach the out-of-pocket maximum, the plan pays 100% of covered charges for the remainder of the plan year.

Preferred Provider Organization (PPO)

The PPO plan allows you to use any provider you choose.

- **Doctors/Health Care Providers –** You can choose any doctor you want, and you can go to any hospital or pharmacy. However, you'll pay less when you use a provider or facility that participates in-network.
- **Preventive Care –** Preventive care is 100% covered when you use in-network providers. Visit healthcare.gov/preventive-care-benefits/ for a complete list of preventive care benefits required to be covered at 100% per the Affordable Care Act.
- **Annual Deductible –** You generally pay an annual deductible before the plan begins to pay for a portion of covered medical services
- **Paying for Care – When you receive medical care, there are two ways you pay for services:**
  - **Copays –** When you go to an in-network doctor for an office visit, go to the emergency room, or pick up a prescription, you pay a set dollar amount called a copay (you may need to pay the annual deductible first before the copay applies).
  - **Coinsurance –** When you receive any other medical services, you pay a percentage of the cost of the service and the plan pays the remaining percentage. This is called coinsurance (you will need to pay the annual deductible first before coinsurance applies).
- **Annual Out-of-Pocket Maximum –** The PPO includes an out-of-pocket maximum. This is the maximum amount you must pay out of your own pocket (under the applicable coinsurance percentage) after meeting the deductible. Once you reach the out-of-pocket maximum, the plan pays 100% of in-network charges for the remainder of the plan year. Please note that your out-of-pocket maximum will be lower when you use in-network providers.



WHAT'S NEW

CALPERS PLAN CHANGES FOR 2026

Health Plan Changes

Health Plan	Changes
Basic Plans • Anthem Blue Cross Traditional • Anthem Blue Cross Select • Health Net Salud y Más • PERS Gold Basic • PERS Platinum Basic • Sharp Health Plan Performance Plus • UnitedHealthcare SignatureValue Alliance • UnitedHealthcare SignatureValue Harmony • Western Health Advantage **Medicare Plans** • Anthem Blue Cross Medicare Preferred • PERS Gold Medicare Supplement • PERS Platinum Medicare Supplement	Effective January 1, 2026, CVS Caremark *(CVS) will replace OptumRx as the new pharmacy benefits manager (PBM).* For more information on changes visit CVS Caremark Pharmacy Benefits. Health plans not listed are not affected by this change.
Blue Shield Access+	Expansion into Monterey County[1]
Blue Shield Trio	Exits Monterey County

Benefit Design Changes

Benefit	Changes
Value-Based Insurance Design (VBID)	Will continue with in-patient deductible credits of up to $500 for completing an expanded menu of preventive care activities such as cancer screenings, vaccinations, depression screening, or participation in a Diabetes Prevention Program *(if applicable)*

1 Contingent upon approval from the Department of Managed Health Care (DMHC).

2026 CalPERS – EPO & HMO Basic Plans

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet. All benefits subject to regulatory approval.

Benefits	Anthem Blue Cross Select HMO Traditional HMO	Blue Shield Access+ HMO EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	United-Healthcare Signature-Value Alliance & Harmony	Western Health Advantage HMO
Calendar Year Deductible							
• Individual	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Family	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Maximum Calendar Year Copay or Coinsurance *(excluding pharmacy)*							
• Individual	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)	$1,500 (copay)
• Family	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)	$3,000 (copay)
Hospital *(including Mental Health and Substance Abuse)*							
• Deductible *(per admission)*	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Inpatient	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient Facility/Surgery Services	No Charge	No Charge	No Charge	$15	No Charge	No Charge	No Charge
Emergency Services							
• Emergency Room Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Emergency *(copay waived if admitted as an inpatient or for observation as an outpatient)*	$50	$50	$50	$50	$50	$50	$50
• Non-Emergency *(copay waived if admitted as an inpatient or for observation as an outpatient)*	$50	$50	$50	$50	$50	$50	$50
Physician Services *(including Mental Health and Substance Abuse)*							
• Office Visits *(copay for each service provided)*	$15	$15	$15	$15	$15	$15	$15
• Inpatient Visits	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient Visits	$15	$15	$15	$15	$15	$15	$15
• Urgent Care Visits	$15	$15	$15	$15	$15	$15	$15
• Preventive Services	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Surgery/ Anesthesia	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

2026 CalPERS – EPO & HMO Basic Plans (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet. All benefits subject to regulatory approval.

Benefits	Anthem Blue Cross Select HMO Traditional HMO	Blue Shield Access+ HMO EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	United-Healthcare Signature-Value Alliance & Harmony	Western Health Advantage HMO
Diagnostic X-ray/Lab	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Prescription Drugs							
• Deductible	N/A	N/A	N/A	N/A	N/A	N/A	N/A
• Retail Pharmacy *(30-day supply)*	Tier 1: $5 Tier 2: $20 Tier 3: $50	Tier 1: $5 Tier 2: $20 Tier 3: $50 Tier 4: $30	Tier 1: $5 Tier 2: $20 Tier 3: $50	Generic: $5 Brand: $20	Tier 1: $5 Tier 2: $20 Tier 3: $50	Tier 1: $5 Tier 2: $20 Tier 3: $50	Tier 1: $5 Tier 2: $20 Tier 3: $50
• Retail Pharmacy *(90-day supply)*	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100 Tier 4: $60 (Retail Preferred Pharmacy Maintenance Medications)	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100
• Mail Order Pharmacy Program *(not to exceed 90-day supply for maintenance drugs)*	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100 Tier 4: $60	Tier 1: $10 Tier 2: $40 Tier 3: $100	Generic: $10 Brand: $40 (31-100 day supply)	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100	Tier 1: $10 Tier 2: $40 Tier 3: $100
• Mail order maximum copayment per person per calendar year	$1,000	$1,000	$1,000	N/A	$1,000	$1,000	$1,000
Durable Medical Equipment	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Infertility Testing/ Treatment	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges	50% of Covered Charges
Occupational /Physical /Speech Therapy							
• Inpatient *(hospital or skilled nursing facility)*	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
• Outpatient *(office and home visits)*	$15	$15	$15	$15	$15	$15	$15

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2026 CalPERS – EPO & HMO Basic Plans (continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet. All benefits subject to regulatory approval.

Benefits	Anthem Blue Cross Select HMO Traditional HMO	Blue Shield Access+ HMO EPO Trio HMO	Health Net	Kaiser Permanente	Sharp Performance Plus	United-Healthcare Signature-Value Alliance & Harmony	Western Health Advantage HMO
Diabetes Services							
• Glucose monitors	Coverage varies	No Charge	Coverage varies	No Charge	Coverage varies	Coverage varies	Coverage varies
• Self-management training	$15	$15	$15	$15	$15	$15	$15
Acupuncture	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)
Chiropractic	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)	$15/visit (acupuncture/ chiropractic; combined 20 visits per calendar year)
Pregnancy & Maternity Care	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge

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2026 CalPERS – PPO Basic Plans

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet. All benefits subject to regulatory approval.

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Calendar Year Deductible						
• Individual	$1,000 [1,3]	$2,500 [3]	$500 [3]	$2,000 [3]	$300	$600
• Family	$2,000 [1,3]	$5,000 [3]	$1,000 [3]	$4,000 [3]	$900	$1,800
Maximum Calendar Year Copay or Coinsurance *(excluding pharmacy)*						
• Individual	$3,000 (coinsurance)	Unlimited	$2,000 (coinsurance)	Unlimited	$2,000	$2,000
• Family	$6,000 (coinsurance)	Unlimited	$4,000 (coinsurance)	Unlimited	$4,000	$4,000
Hospital *(including Mental Health and Substance Abuse)*						
• Deductible *(per admission)*	N/A		$250 (copay)		N/A	
• Inpatient	20% [2]	40% [4]	10%	40% [4]	20%	20% [4]
• Outpatient Facility/ Surgery Services	20%	40% [4]	10%	40% [4]	20%	20% [4]
Emergency Services						
• Emergency Room Deductible	$50 (applies to hospital emergency room facility charge only)		$50 (applies to hospital emergency room facility charge only)		N/A	
• Emergency	20% (applies to other services such as physician, x-ray, lab, etc.)		10% (applies to other services such as physician, x-ray, lab, etc.)		20%	
• Non-Emergency	20%	40%	10%	40%	50%	
	(payment for physician charges only; emergency room facility charge is not covered)		(payment for physician charges only; emergency room facility charge is not covered)		(for non-emergency services provided by hospital emergency room)	

1 Incentives available to reduce individual inpatient deductible (max. $500) or family deductible (max. $1,000). Refer to EOC for details.

2 Coinsurance waived for deliveries if enrolled in Included Health's Maternity Program by the 24th week of pregnancy. For deliveries after April 2026, member must be enrolled by January 1, 2026.

3 Deductible is not transferable between PERS Gold and PERS Platinum.

4 Of the allowable amount as defined in the EOC.

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2026 CalPERS – PPO Basic Plans
(continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet. All benefits subject to regulatory approval.

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Physician Services *(including Mental Health and Substance Abuse)*						
• Office Visits *(copay for each service provided)*	$35 [1,2]	40% [3]	$20 [2]	40% [3]	$10/$35 [2]	20% [3]
• Inpatient Visits	20%	40% [3]	10%	40% [3]	20%	20% [3]
• Outpatient Visits	$35	40% [3]	$20	40% [3]	20%	20% [3]
• Urgent Care Visits	$35	40% [3]	$35	40% [3]	$35	20% [3]
• Preventive Services	No Charge	40% [3]	No Charge	40% [3]	No Charge	
• Surgery/Anesthesia	20%	40% [3]	10%	40% [3]	20%	20% [3]
Diagnostic X-Ray/Lab	20% [4]	40% [3]	10% [4]	40% [3]	20%	20% [3]

1 Reduced to $10 when seen by matched primary physician.
2 $35 for specialist visit.
3 Of the allowable amount as defined in the EOC.
4 For lab services only — no charge when using Quest Diagnostic or Labcorp.

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2026 CalPERS – PPO Basic Plans
(continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet. All benefits subject to regulatory approval.

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Prescription Drugs						
• Deductible	N/A		N/A		N/A	
• Retail Pharmacy *(30-day supply)*	Tier 1: $5 Tier 2: $20 Tier 3: $50		Tier 1: $5 Tier 2: $20 Tier 3: $50		Generic: $10 Brand Formulary: $25 Non-Formulary: $45 Compound: $45	
• Retail Pharmacy *(90-day supply)*	Tier 1: $10 Tier 2: $40 Tier 3: $100		Tier 1: $10 Tier 2: $40 Tier 3: $100		N/A	
• Mail Order Pharmacy Program *(not to exceed 90-day supply for maintenance drugs)*	Tier 1: $10 Tier 2: $40 Tier 3: $100		Tier 1: $10 Tier 2: $40 Tier 3: $100		Generic: $20 Brand Formulary: $40 Non-Formulary: $75	N/A
• Mail Order Maximum Copayment Per Person Per Calendar Year	$1,000		$1,000		N/A	
Durable Medical Equipment	20%	40% [1]	10%	40% [1]	20%	20% [1]
	(pre-certification required for specific equipment)		(pre-certification required for the purchase of equipment priced at $1,000 or more)			

1 Of the allowable amount as defined in the EOC.

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2026 CalPERS – PPO Basic Plans
(continued)

For more details about the benefits provided by a specific plan, refer to that plan's Evidence of Coverage (EOC) booklet. All benefits subject to regulatory approval.

Benefits	PERS Gold		PERS Platinum		PORAC (Association Plan)	
	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Infertility Testing/ Treatment	50%		50%		50%	50% [2]
Occupational / Physical / Speech Therapy						
• Inpatient *(hospital or skilled nursing facility)*	No Charge		No Charge		20%	20% [2]
• Outpatient *(office and home visits)*	20%	40% (Occupational therapy: 20%)	10%	40% (Occupational therapy: 10%)	20%	20% [2]
	(pre-certification required for more than 24 visits)		(Pre-certification required for more than 24 visits)			
Diabetes Services						
• Glucose monitors	Coverage Varies		Coverage Varies		Coverage Varies	
• Self-management training	$20 [1]	40% [2]	$20 [1]	40% [2]	$20	60% [2]
Acupuncture	$15/Visit	40% [2]	$15/Visit	40% [2]	20%	20% [2]
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)	
Chiropractic	$15/Visit	40% [2]	$15/Visit	40% [2]	20%	20% [2]
	(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)		(acupuncture/chiropractic; combined 20 visits per calendar year)	
Pregnancy & Maternity Care	20% [3]	40%	10%	40%	80%	80%

1 $35 for specialist visit.

2 Of the allowable amount as defined in the EOC.

3 Coinsurance waived for deliveries if enrolled in Included Health's Maternity Program by the 24th week of pregnancy. For deliveries after April 2026, member must be enrolled by January 1, 2026.

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Medical Rates

BU: GEN, PROF, CONF, DSA, MEA, DH, ELECTED, BOS, PPOA, DDA-DPD, SMA

							HEALTH ONLY		DEN/VIS Only		Full Election	
Plan	**Medical Premium**	**Dental**	**Vision**	**Total Premium**	**Co Medical Contribution per Month**	**Additional Co Contribution for D/V Election**	**Total County Contribution**	**Total Employee Cost per Month**	**Total County Contribution**	**Total Employee Cost per Month**	**Total County Contribution**	**Total Employee Cost per Month**
PERS Gold - County Sponsored Plan												
• Employee Only	$1,120.58	$64.18	$19.20	$1,203.96	$1,120.58	$83.38	$1,120.58	$0.00	$83.38	$0.00	$1,203.96	$0.00
• Employee + 1	$2,241.16	$116.97	$32.05	$2,390.18	$2,033.19	$119.22	$2,033.19	$207.97	$119.22	$29.80	$2,152.41	$237.77
• Employee & 2 +	$2,913.51	$221.17	$57.60	$3,192.28	$2,634.69	$223.02	$2,634.69	$278.82	$223.02	$55.75	$2,857.70	$334.58
Anthem Blue Cross Select HMO												
• Employee Only	$1,336.29	$64.18	$19.20	$1,419.67	$1,257.47	$83.38	$1,257.47	$78.82	$83.38	$0.00	$1,340.85	$78.82
• Employee + 1	$2,672.58	$116.97	$32.05	$2,821.60	$2,033.19	$119.22	$2,033.19	$639.39	$119.22	$29.80	$2,152.41	$669.19
• Employee & 2 +	$3,474.35	$221.17	$57.60	$3,753.12	$2,634.69	$223.02	$2,634.69	$839.66	$223.02	$55.75	$2,857.70	$895.42
Anthem Blue Cross Traditional HMO												
• Employee Only	$1,612.08	$64.18	$19.20	$1,695.46	$1,257.47	$83.38	$1,257.47	$354.61	$83.38	$0.00	$1,340.85	$354.61
• Employee + 1	$3,224.16	$116.97	$32.05	$3,373.18	$2,033.19	$119.22	$2,033.19	$1,190.97	$119.22	$29.80	$2,152.41	$1,220.77
• Employee & 2 +	$4,191.41	$221.17	$57.60	$4,470.18	$2,634.69	$223.02	$2,634.69	$1,556.72	$223.02	$55.75	$2,857.70	$1,612.48
Blue Shield Access+ HMO												
• Employee Only	$1,301.95	$64.18	$19.20	$1,385.33	$1,257.47	$83.38	$1,257.47	$44.48	$83.38	$0.00	$1,340.85	$44.48
• Employee + 1	$2,603.90	$116.97	$32.05	$2,752.92	$2,033.19	$119.22	$2,033.19	$570.71	$119.22	$29.80	$2,152.41	$600.51
• Employee & 2 +	$3,385.07	$221.17	$57.60	$3,663.84	$2,634.69	$223.02	$2,634.69	$750.38	$223.02	$55.75	$2,857.70	$806.14
Blue Shield Trio HMO												
• Employee Only	$1,166.58	$64.18	$19.20	$1,249.96	$1,166.58	$83.38	$1,166.58	$0.00	$83.38	$0.00	$1,249.96	$0.00
• Employee + 1	$2,333.16	$116.97	$32.05	$2,482.18	$2,033.19	$119.22	$2,033.19	$299.97	$119.22	$29.80	$2,152.41	$329.77
• Employee & 2 +	$3,033.11	$221.17	$57.60	$3,311.88	$2,634.69	$223.02	$2,634.69	$398.42	$223.02	$55.75	$2,857.70	$454.18

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Medical Rates (continued)

BU: GEN, PROF, CONF, DSA, MEA, DH, ELECTED, BOS, PPOA, DDA-DPD, SMA

							HEALTH ONLY		DEN/VIS Only		Full Election	
Plan	**Medical Premium**	**Dental**	**Vision**	**Total Premium**	**Co Medical Contribution per Month**	**Additional Co Contribution for D/V Election**	**Total County Contribution**	**Total Employee Cost per Month**	**Total County Contribution**	**Total Employee Cost per Month**	**Total County Contribution**	**Total Employee Cost per Month**
Kaiser Permanente												
• Employee Only	$1,168.86	$64.18	$19.20	$1,252.24	$1,168.86	$83.38	$1,168.86	$0.00	$83.38	$0.00	$1,252.24	$0.00
• Employee + 1	$2,337.72	$116.97	$32.05	$2,486.74	$2,033.19	$119.22	$2,033.19	$304.53	$119.22	$29.80	$2,152.41	$334.33
• Employee & 2 +	$3,039.04	$221.17	$57.60	$3,317.81	$2,634.69	$223.02	$2,634.69	$404.35	$223.02	$55.75	$2,857.70	$460.11
UnitedHealthcare SignatureValue Alliance												
• Employee Only	$1,290.06	$64.18	$19.20	$1,373.44	$1,257.47	$83.38	$1,257.47	$32.59	$83.38	$0.00	$1,340.85	$32.59
• Employee + 1	$2,580.12	$116.97	$32.05	$2,729.14	$2,033.19	$119.22	$2,033.19	$546.93	$119.22	$29.80	$2,152.41	$576.73
• Employee & 2 +	$3,354.16	$221.17	$57.60	$3,632.93	$2,634.69	$223.02	$2,634.69	$719.47	$223.02	$55.75	$2,857.70	$775.23
UnitedHealthcare SignatureValue Harmony												
• Employee Only	$1,133.09	$64.18	$19.20	$1,216.47	$1,133.09	$83.38	$1,133.09	$0.00	$83.38	$0.00	$1,216.47	$0.00
• Employee + 1	$2,266.18	$116.97	$32.05	$2,415.20	$2,033.19	$119.22	$2,033.19	$232.99	$119.22	$29.80	$2,152.41	$262.79
• Employee & 2 +	$2,946.03	$221.17	$57.60	$3,224.80	$2,634.69	$223.02	$2,634.69	$311.34	$223.02	$55.75	$2,857.70	$367.10
Western Health Advantage HMO												
• Employee Only	$969.58	$64.18	$19.20	$1,052.96	$969.58	$83.38	$969.58	$0.00	$83.38	$0.00	$1,052.96	$0.00
• Employee + 1	$1,939.16	$116.97	$32.05	$2,088.18	$1,939.16	$119.22	$1,939.16	$0.00	$119.22	$29.80	$2,058.38	$29.80
• Employee & 2 +	$2,520.91	$221.17	$57.60	$2,799.68	$2,520.91	$223.02	$2,520.91	$0.00	$223.02	$55.75	$2,743.93	$55.75
PERS Platinum												
• Employee Only	$1,670.14	$64.18	$19.20	$1,753.52	$1,257.47	$83.38	$1,257.47	$412.67	$83.38	$0.00	$1,340.85	$412.67
• Employee + 1	$3,340.28	$116.97	$32.05	$3,489.30	$2,033.19	$119.22	$2,033.19	$1,307.09	$119.22	$29.80	$2,152.41	$1,336.89
• Employee & 2 +	$4,342.36	$221.17	$57.60	$4,621.13	$2,634.69	$223.02	$2,634.69	$1,707.67	$223.02	$55.75	$2,857.70	$1,763.43

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Medical Rates (continued)

BU: GEN, PROF, CONF, DSA, MEA, DH, ELECTED, BOS, PPOA, DDA-DPD, SMA

							HEALTH ONLY		DEN/VIS Only		Full Election	
Plan	**Medical Premium**	**Dental**	**Vision**	**Total Premium**	**Co Medical Contribution per Month**	**Additional Co Contribution for D/V Election**	**Total County Contribution**	**Total Employee Cost per Month**	**Total County Contribution**	**Total Employee Cost per Month**	**Total County Contribution**	**Total Employee Cost per Month**
PORAC *(Available to PORAC Members Only - In State Rate)*												
• Employee Only	$1,063.00	$64.18	$19.20	$1,146.38	$1,063.00	$83.38	$1,063.00	$0.00	$83.38	$0.00	$1,146.38	$0.00
• Employee + 1	$2,418.00	$116.97	$32.05	$2,567.02	$2,033.19	$119.22	$2,033.19	$384.81	$119.22	$29.80	$2,152.41	$414.61
• Employee & 2 +	$3,027.00	$221.17	$57.60	$3,305.77	$2,634.69	$223.02	$2,634.69	$392.31	$223.02	$55.75	$2,857.70	$448.07
OUT OF STATE OPTIONS												
PERS Platinum												
• Employee Only	$1,410.29	$64.18	$19.20	$1,493.67	$1,257.47	$83.38	$1,257.47	$152.82	$83.38	$0.00	$1,340.85	$152.82
• Employee + 1	$2,820.58	$116.97	$32.05	$2,969.60	$2,033.19	$119.22	$2,033.19	$787.39	$119.22	$29.80	$2,152.41	$817.19
• Employee & 2 +	$3,666.75	$221.17	$57.60	$3,945.52	$2,634.69	$223.02	$2,634.69	$1,032.06	$223.02	$55.75	$2,857.70	$1,087.82
PORAC *(Available to PORAC Members Only - Out of State Rate)*												
• Employee Only	$1,206.00	$64.18	$19.20	$1,289.38	$1,206.00	$83.38	$1,206.00	$0.00	$83.38	$0.00	$1,289.38	$0.00
• Employee + 1	$2,448.00	$116.97	$32.05	$2,597.02	$2,033.19	$119.22	$2,033.19	$414.81	$119.22	$29.80	$2,152.41	$444.61
• Employee & 2 +	$2,900.00	$221.17	$57.60	$3,178.77	$2,634.69	$223.02	$2,634.69	$265.31	$223.02	$55.75	$2,857.70	$321.07

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Dental

When it comes to choosing a dental plan, you want benefits that fit the needs of you and your family. Ameritas Dental PPO offers comprehensive dental coverage, quality care and excellent customer service.

Website: www.ameritas.com
Customer Service Number: 800-487-5553
Customer Service Email: group@ameritas.com
Contract/Group Number: 010-302140
Classic (PPO) & Plus

Ameritas Dental PPO

Ameritas Dental PPO, our preferred provider organization (PPO) plan, provides access to the largest PPO dentist network in the U.S. Ameritas Dental PPO dentists agree to accept reduced fees for covered procedures when treating PPO patients. This means your out-of-pocket costs are usually lower when you visit a PPO dentist than when you visit a non-Ameritas Dental PPO dentist, but you have the freedom to visit any licensed dentist, anywhere in the world. Although the percentages of benefits are the same no matter which dentist you choose, your out-of-pocket expenses may be greater if you choose a non-Ameritas Dental PPO Dentist.

Plan Benefits	Ameritas Dental PPO	
	In-Network Classic (PPO) & Plus	Out-of-Network
General Plan Information		
• Annual Deductible *(Individual/Family)*	$0/$0	$0/$0
• Annual Plan Maximum	$2,500	$2,500
Type 1 Services		
• Diagnostic and Preventive	100%	100%
• Oral Exams	100%	100%
• Bitewing X-rays	100%	100%
• Full Mouth X-rays	100%	100%
• Cleaning and Scaling	100%	100%
• Prophylaxis Treatments	100%	100%
• Fluoride Treatments	100%	100%
• Space Maintainers	100%	100%
• Sealants	100%	100%
Type 2 Services		
• Basic	100%	100%
• Oral Surgery *(Extractions and Other Surgical Procedures)*	100%	100%
• Endodontic Treatment	100%	100%

For more information on your Ameritas Dental Plan, please visit www.ameritas.com.

To look up an in-network dental provider, please visit https://www.ameritas.com/employee-benefits/find-a-provider/ and select the Classic (PPO) & Plus Network from the drop-down.

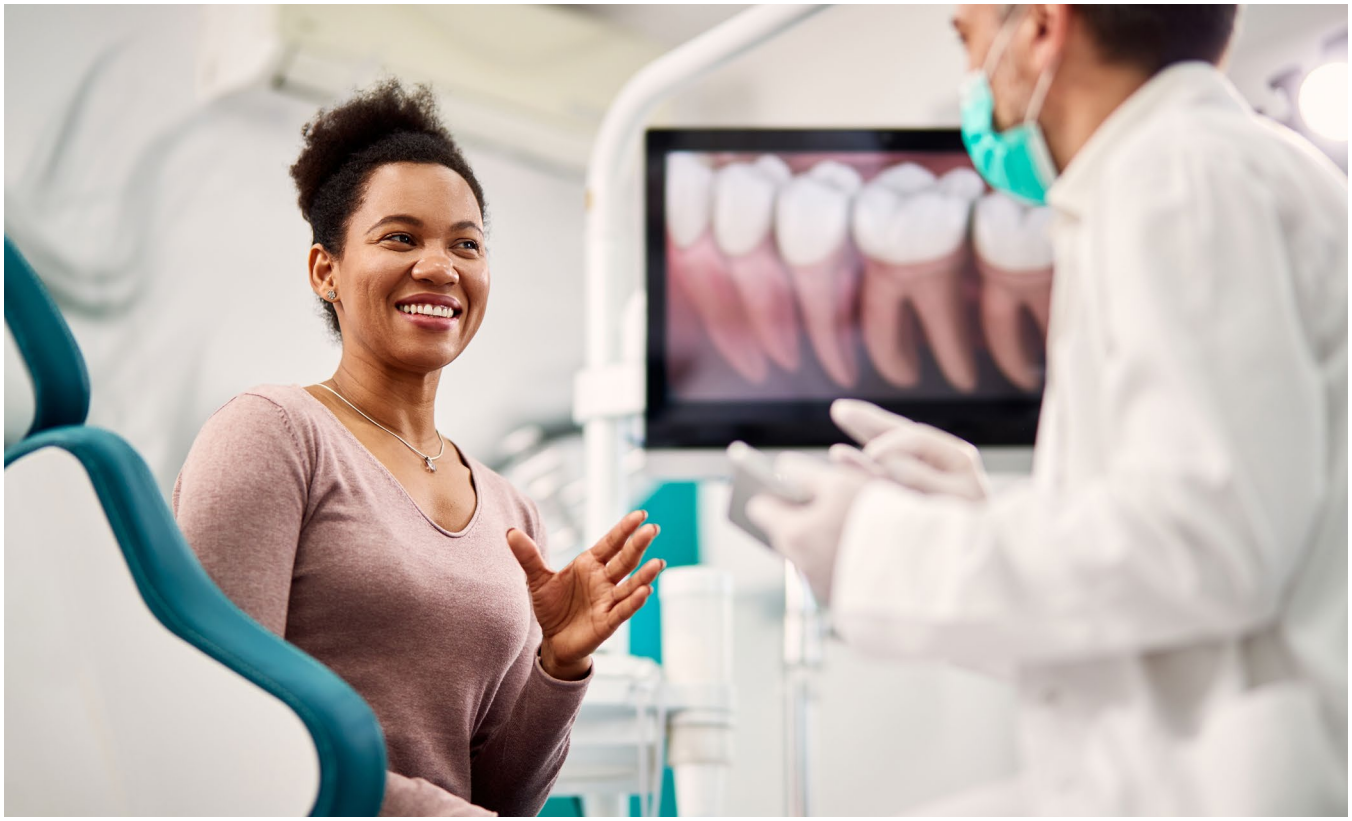
The information described on this page is only intended to be a summary of benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review plan documents for full details. If there are any conflicts with information provided on this page, the plan documents will prevail.

Dental (continued)

Plan Benefits	Ameritas Dental PPO	
	In-Network Classic (PPO) & Plus	Out-of-Network
• Periodontic Treatment	100%	100%
Type 3 Services		
• Major	80%	80%
• Crowns, Jackets and Cast Restorations	80%	80%
• Implants	80%	80%
Type 4 Services		
• Bridges	50%	50%
• Dentures	50%	50%
• Denture Repair	50%	50%
• Prosthodontic Benefits *(Fixed Bridges, Partial/Complete Dentures)*	50%	50%
Orthodontia		
• Child and Adult	50% $2,500 Lifetime Maximum	50% $2,500 Lifetime Maximum

For more information on your Ameritas Dental Plan, please visit www.ameritas.com.

To look up an in-network dental provider, please visit https://www.ameritas.com/employee-benefits/find-a-provider/ and select the Classic (PPO) & Plus Network from the drop-down.

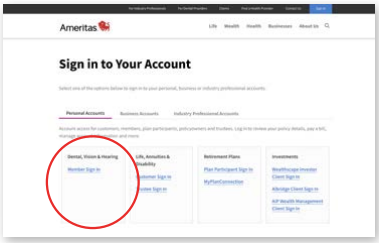


Find a Network Dentist

Find your Ameritas Dental Network name

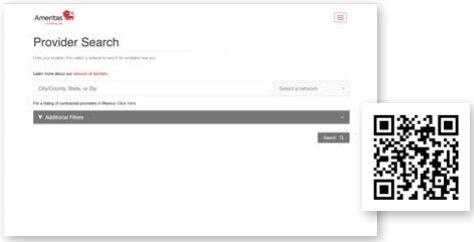
There are several ways to find your network name:

- Check your dental ID card or plan materials.
- Call customer connections at 800-487-5553 – in NY, 800-659-5556.
- Sign in to your member account.
- Download the Ameritas Benefits app for iOS or Android. Log in with the same email address and password you use for your member account.



Search online

- Visit ameritas.com – Find a Health Provider to find a new dentist or see if your current provider is in the Ameritas Dental Network.
- For a list of providers that allow you to use your in-network benefits in Mexico, select Find a Contracted Provider in Mexico.



Find a dentist

- Enter your location, then choose your network name to search for a provider near you.
- When you search for providers within your account or the Ameritas Benefits app, you will find providers in your network.
- Network providers charge 25-50% less than their regular rates.
- Use Additional Filters to search by provider name, practice/business name, or specialty.
- If you can't find a specific provider or location by name, search by ZIP Code or city.

Nominate your dentist. If your dentist is not in your network already, just go to ameritas.com, search for "nominate a provider" and complete the online form.

Help us improve. We do our best to keep our records updated. If you find a phone number that is no longer in service, or if a provider is no longer at that location, please select the Report Inaccurate Information link within the directory listing.

Ameritas
fulfilling life.

Ameritas Life Insurance Corp.
Ameritas Life Insurance Corp. of New York

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Easily Manage Your Dental Benefits

Here's what you can do now to get the most from your plan.

Member account registration

After your benefit effective date:

1. Go to **ameritas.com/sign-in** and select Member Sign In under Dental, Vision & Hearing.
2. Choose your account type, validate your identity, and follow the prompts to create your account.

Need help registering?
Follow this step-by-step registration guide.

Learn more about the features available in your member account.

Getting started in your account:

- Print or save your **ID card** to your smartphone.
- Review your **plan details** including maximum benefit, deductible amounts and your remaining benefits.
- Check if your current provider is part of the **Ameritas Dental Network**.
- See how **benefits** are calculated and payments are processed in the claims tab.
- Go **paperless** and sign up to receive your explanation of benefits (EOB) statements online.

Additional plan benefits in your member account

Save more with Ameritas

Ameritas offers money-saving discounts to help with hearing, prescription and eyewear expenses. These savings arrangements are not insurance and are available to Ameritas plan members at no additional cost to the plan premium. Access savings cards using the QR code or through your account at ameritas.com.

Worldwide support

AXA Assistance helps find a provider and schedule an appointment if you have a dental or vision emergency while traveling outside the U.S.

Save these numbers:
866-662-2731 (toll free)
and 312-935-3727 (collect)

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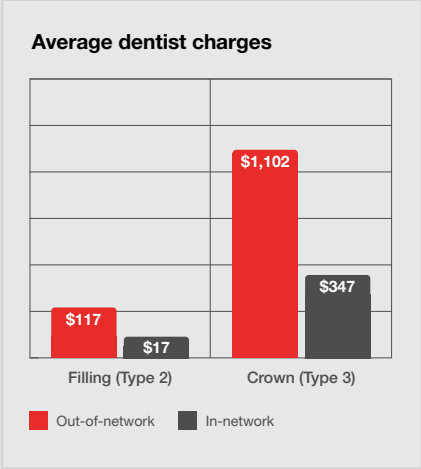
Evaluate your potential out-of-pocket costs

- Located in your member account, the dental cost estimator lets you compare estimated procedure charges based on ZIP Code. You can search estimates for both in-network and out-of-network providers.
- Ask your dentist to submit a pretreatment estimate for any dental work you consider expensive. Then Ameritas will let you know the amount insurance will cover so you can budget for the remainder. The pretreatment estimate is based on your plan benefits and submitted claims.



For illustrative purposes only. Allowance and cost estimates are specific to ZIP Code 605XXX. The initial cost without insurance has been estimated. Actual charges may vary.

Save money

You can use your dental benefits with any provider. But consider that out-of-network dentists will charge you their regular rates, whereas Ameritas network providers have agreed to charge you 25-50% less. After your plan benefits are applied, you pay the remaining balance.

See if your dentist is in-network

Visit ameritas.com, Find a Health Provider, to find a new dentist or see if your current provider is in the Ameritas Dental Network. You also can view a list of contracted providers in Mexico.

Nominate your dental provider

If your dentist is not in the network already, just go to ameritas.com, search for nominate a provider and complete the online form.

Here to help

For plan information any time, visit ameritas.com and sign in to your member account. Or download the Ameritas Benefits app available for iOS and Android. Log in with the same email address and password you use for your member account.

If you have questions about your plan benefits, contact the Ameritas customer connections team.

group@ameritas.com | 800-487-5553

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Vision

The County offers a vision plan through Ameritas Vision. The plan pays benefits and offers discounts for most vision care expenses you incur while covered by the plan, subject to the maximum amounts shown below. If you use Ameritas Vision providers, your costs for most services and materials are limited to the applicable copays. To find more information on Ameritas Vision or to locate a provider, visit www.ameritas.com.

Website: www.ameritas.com
Customer Service Number: 800-487-5553
Contract/Group Number: 010-302140

Plan Benefits	Description	Copay	Frequency
Wellvision Exam	• Focuses on your eyes and overall wellness	$10	Every calendar year
Prescription Glasses			
• Frame	• $300 allowance for a wide selection of frames • 20% savings on the amount over your allowance	Covered in full	Every calendar year
• Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Std. Polycarbonate lenses for dependent children	Covered in full	Every calendar year
• Lens Enhancements	• Anti-glare coating • Progress Lenses	• $39 - $75 • Up to provider's contracted fee	Every calendar year
Contacts *(Instead of Glasses)*	• $200 allowance for contacts; copay does not apply • Contact lens exam *(fitting and evaluation)*	Up to $60	Every calendar year
Extra Savings			
• Glasses and Sunglasses	• 20% savings on additional glasses and sunglasses. Or get 20% from any Ameritas Vision provider within 12 months of your last WellVision Exam.		
• Laser Vision Correction	• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a Ameritas Vision network doctor. Call Member Services for out-of-network plan details.

Coverage with a retail chain may be different or not apply. Log in to www.ameritas.com to check your benefits for eligibility and to confirm in-network locations based on your plan type. Ameritas Vision guarantees coverage from Ameritas Vision network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with Ameritas Vision, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

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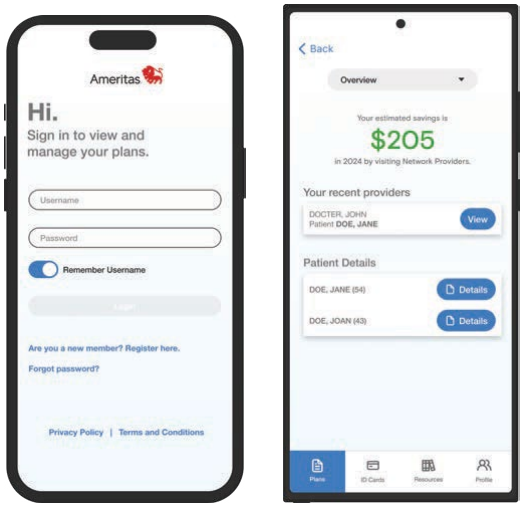
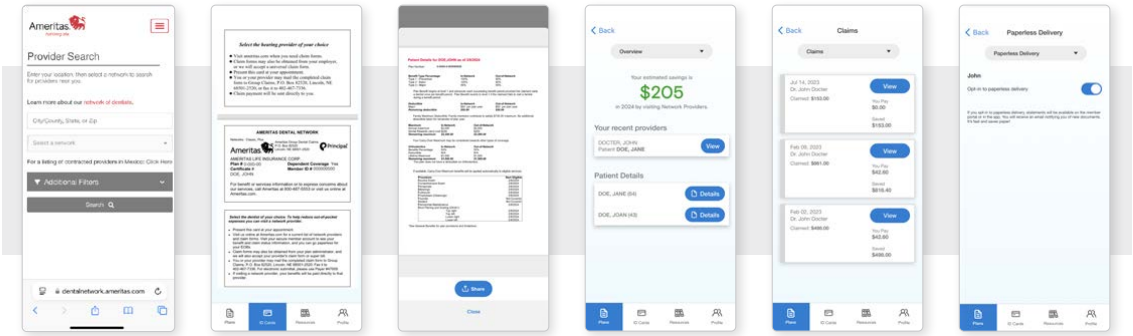
Download the Ameritas Benefits App

If you have an Ameritas member account, you can download the Ameritas Benefits app to easily search for providers, view dental benefits and processed claims, and access ID cards once benefits become effective.

Available for iOS and Android



FEATURES



Find a dentist in your area.

Quickly access all your ID cards.*

Access your benefit information.*

View deductible and maximum benefit usage.

View and download EOBs.

Opt-in to paperless delivery.

Download the Ameritas Benefits app today. Log in with the same email address and password you use for your member account.

Download on the App Store

GET IT ON Google Play

Ameritas fulfilling life.

*Additional access includes vision and LASIK benefit information when applicable.

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Basic and Voluntary Life

Life Insurance

Employer-Paid Basic Life and AD&D

Website: www.voya.com
Customer Service Number: 800-955-7736
Contract/Group Number: 716405

The County provides group life and accidental death and dismemberment insurance through Voya. This benefit is fully paid for by The County. Eligible employees are all regular employees working at least 20 hours per week.

- **Full-time Appointed & Elected Department Heads & County Executive:**
  - The policy value is 2x salary up to $500,000.
- **All Other Full-Time Eligible Employees:**
  - The policy value is $50,000

Don't Forget to Name a Beneficiary

A beneficiary is the person or persons who will be paid if you die while covered by the plan. A person becomes your beneficiary only if you have named them when you enrolled. List your beneficiaries on the BenefitBridge Portal.

Employee-Paid Voluntary Term Life

	Voluntary Employee Life	Voluntary Spouse Life	Voluntary Child Life
Coverage Amount	Supplement Life and AD&D of $20,000 to $500,000 in $10,000 increments. The total amount cannot exceed 5x your basic earnings.	Supplement Life and AD&D of $5,000 to $250,000 in $5,000 increments. The total cannot exceed more than 50% of the employee coverage	Supplement Life and AD&D of $1,000, $5,000 or $10,000 from live birth to age 26.
Guaranteed Issue	Up to $200,000 without EOI during the current enrollment period.	Up to $50,000 without EOI during current enrollment period.	Not applicable
Evidence of Insurability (EOI)	Up to $500,000 if EOI is approved	Up to $250,000 if EOI is approved	Not applicable
Increases in coverage	You can increase coverage up to a total of $40,000 up to $200,000 without EOI during the annual open enrollment. Higher amounts are subject to EOI.	You can increase coverage up to a total of $10,000 up to $50,000 without EOI during the annual open enrollment. Higher amounts are subject to EOI.	You can increase coverage up to $10,000 without EOI during the annual open enrollment.
New Hires	Up to $200,000 without EOI	Up to $50,000 without EOI	Up to $10,000 without EOI
Late Entrants	EOI Required	EOI Required	Not applicable
Age Reductions	Benefit amount reduces to 65% at age 70 and 50% at age 75.		

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Voluntary Coverage

You can contact Building Blocks-Colonial to schedule at any time
by calling 844-624-1380 or click on the below links:

Book Remote Meeting: https://countyofnv.youcanbook.me

As an Employee of the County we are excited to announce benefit options available to you through Colonial Life with assistance from the enrollment firm Building Blocks for Business. Please schedule your appointment with a Building Blocks-Colonial representative today.

The Following Benefits are Now Available

- **Accident 101:** For a covered accident, policyholders receive cash benefits for use as they see fit.
- **Cancer Assist:** The cancer plan is designed to pay cash benefits that can be used to help offset cancer-related expenses.
- **Critical Illness 1.0:** Helps with medical expenses related to a covered serious health event.
- **Life Insurance:** Helps with peace of mind knowing your family is taken care of.
- **Medical Bridge 7000/Hospital Confinement:** Pays cash amounts to help with non-covered expenses of a hospital stay.

** See the following pages for plan descriptions & rates

A Building Blocks Benefit Advisor will assist you with your enrollment via Telephone or Screen Share Enrollment Session (requires access to a computer and internet), whichever you prefer.

Receive membership to the WellCard Savings Program

After completing your enrollment session with a Building Blocks Benefit Advisor, you will receive your membership login information to the WellCard Savings Program!

You and your family will have access to receive discounts on Medical, Pharmacy, Vision & Dental Care, Health & Wellness, Pet Discounts, and more.

Accident 101

Colonial Life's voluntary accident insurance policy is a medical indemnity plan that provides employees and their families with hospital, doctor, accidental death and catastrophic accident benefits in the event of a covered accident.

Base Policy Benefits	Basic	Preferred	Premier
Accident Emergency Treatment • For treatment in a doctor's office, urgent care facility, emergency room within the first 72 hours of the accident. • If initially treated after 72 hours, please see Accident Follow-up Doctor's Visit	$75	$125	$125
Accident Follow-Up Doctor Visit	$50/visit up to 2 visits per accident	$50/visit up to 3 visits per accident	$50/visit up to 4 visits per accident
Accidental Death	$20,000 Employee $20,000 Spouse $4,000 Child(ren)	$25,000 Employee $25,000 Spouse $5,000 Child(ren)	$50,000 Employee $50,000 Spouse $10,000 Child(ren)
Accidental Death: Common Carrier	$80,000 Employee $80,000 Spouse $16,000 Child(ren)	$100,000 Employee $100,000 Spouse $20,000 Child(ren)	$200,000 Employee $200,000 Spouse $40,000 Child(ren)
Accidental Dismemberment: *(Loss of Finger/Toe/Hand/Foot or Sight)*	$600- $12,000	$750- $15,000	$1,200-$24,000
Ambulance *(Air)*	$1,200	$2,000	$2,000
Ambulance *(Ground)*	$120	$200	$200
Appliances *(such as wheelchair, crutches)*	$75	$100	$100
Blood/Plasma/Platelets	$300	$300	$300
Burns *(based on size and degree)*	$1,000- $12,000	$1,000- $12,000	$1,000- $12,000
Burns *(Skin Graft)*	50% of burn benefit	50% of burn benefit	50% of burn benefit
Catastrophic Accident – prior to 65 *(For severe injuries that result in the total and irrevocable: loss of one hand and one foot; loss of both hands or both feet; loss of sight in both eyes; loss of hearing of both ears; loss of the ability to speak.)* • 365 day elimination period • Amounts reduced for covered persons over age 65	$10,000 EE/SP $5,000 CH	$25,000 EE/SP $12,500 CH	$25,000 EE/SP $12,500 CH
Coma *(duration of at least 7 days)*	$7,500	$10,000	$12,500
Concussion	$60	$60	$60
Dislocation *(Based on joint and if repaired by open or closed reduction)*	$90-$3,600	$110 - $4,400	$120 - $4,800
Emergency Dental Work	$200 (crown, implant or denture) or $50 (extract)	$300 (crown, implant or denture) or $75 (extract)	$400 (crown, implant or denture) or $100 (extract)
Eye Injury	$200	$300	$300
Fractures *(Based on bone and if repaired by open or closed reduction)*	$90 - $4,500	$110 - $5,500	$120 - $6,000
Hospital Admission*	$750/accident	$1,000/accident	$1,250/accident
Hospital Confinement *(Per day up to 365 days)*	$175	$225	$250
Hospital ICU Admission*	$1,500/accident	$2,000/accident	$2,500/accident
Hospital ICU Confinement *(Up to 15 days per accident)*	$350	$450	$500

Accident 101 (continued)

Base Policy Benefits	Basic	Preferred	Premier
Knee Cartilage *(Torn)*	$500	$500	$750
Laceration *(based on size and repair)*	$30-$500	$30-$500	$30-$500
Lodging *(Companion)*	$100 per day up to 30 days	$125 per day up to 30 days	$150 per day up to 30 days
Medical Imaging Study *(Limit one accident per year)*	$100 per accident	$150 per accident	$200 per accident
Prosthetic Device/Artificial Limb	$500 (1); $1,000 (2 or more)	$500 (1); $1,000 (2 or more)	$750 (1); $1,500 (2 or more)
Rehabilitation Unit Confinement • Up to 15 days per confinement per covered accident. • Maximum of 30 days per calendar year.	$100/day	$100/day	$150/day
Ruptured Disc	$500	$500	$750
Surgery *(Cranial, Open Abdominal, Thoracic)*	$1,000	$1,500	$1,500
Surgery *(Hernia)*	$100	$150	$150
Surgery *(Exploratory or Arthroscopic)*	$150	$200	$200
Tendon/Ligament/Rotator Cuff	$500 (1); $1,000 (2 or more)	$500 (1); $1,000 (2 or more)	$750 (1); $1,500 (2 or more)
Therapy *(Occupational and Physical Therapy Benefit)*	$25 per day (10 visits/accident)	$25 per day (10 visits/accident)	$35 per day (10 visits/accident)
Transportation *(up to 3 trips per accident)*	$400 per trip	$500 per trip	$600 per trip
X-Ray Benefit	$20	$30	$40
Health Screening Benefit *(Per covered person per calendar year)*	$50	$50	$50
Mammography Benefit	$200	$200	$200

* We will pay either the Hospital Admission or Hospital ICU Admission benefit, but not both.

Sample Deductions

Sample CA rates shown include on/off job coverage with Health Screening. Accident coverage is pre-tax eligible.

	Issue Age	Named Insured	Employee & Spouse	One-Parent Family	Two-Parent Family
Semi-monthly Rates (24 Pay Periods)					
Basic	17-64	$10.56	$14.94	$14.87	$19.25
Preferred	17-64	$12.84	$17.96	$18.60	$23.71
Premier	17-64	$15.52	$21.63	$22.11	$28.22

Cancer Assist

Colonial Life's individual cancer insurance product helps to provide valuable financial protection for America's workers and their families in times of need, when medical bills and other expenses related to cancer diagnosis and treatment may limit their ability to focus on what's most important - getting well.

Benefits	Level 1	Level 2	Level 3	Level 4
Air Ambulance *(per trip)*	$2,000	$2,000	$2,000	$2,000
Maximum trips per confinement	2	2	2	2
Ambulance *(per trip)*	$250	$250	$250	$250
Maximum trips per confinement	2	2	2	2
Anesthesia *(General)*	25% of Surgical Procedures Benefit			
Anesthesia *(Local, per procedure)*	$25	$30	$40	$50
Anti-Nausea Medication *(per day)*	$25	$40	$50	$60
Maximum per month	$100	$160	$200	$240
Blood/Plasma/Platelets/ Immunoglobulins *(per day)*	$150	$150	$175	$250
Maximum per calendar year	$10,000	$10,000	$10,000	$10,000
Bone Marrow or Peripheral Stem Cell Donation *(per donation, maximum one per lifetime)*	$500	$500	$750	$1,000
Bone Marrow Stem Cell Transplant *(per transplant)*	$3,500	$4,000	$7,000	$10,000
Peripheral Stem Cell Transplant *(per transplant)*	$3,500	$4,000	$7,000	$10,000
Maximum transplants *(per lifetime)*	2	2	2	2
Companion Transportation *(per mile)*	$0.50	$0.50	$0.50	$0.50
Maximum per round trip	$1,000	$1,000	$1,200	$1,500
Egg (s) Extraction or Harvesting or Sperm Collection *(one per lifetime)*	$500	$700	$1,000	$1,500
Egg (s) or Sperm Storage *(one per lifetime)*	$175	$200	$350	$500
Experimental Treatment *(per day)*	$200	$250	$300	$300
Maximum per lifetime	$10,000	$12,500	$15,000	$15,000
Family Care *(per day)*	$30	$40	$50	$60
Maximum per calendar year	$1,500	$2,000	$2,500	$3,000
Hair/External Breast/ Voice Box Prosthesis *(per calendar year)*	$200	$200	$350	$500

Cancer Assist (continued)

Benefits	Level 1	Level 2	Level 3	Level 4
Home Health Care Services *(per day)*	$50	$75	$100	$150
Maximum per calendar year	**Examples include:** physical therapy, occupational therapy, speech therapy, and audiology, prosthesis and orthopedic appliances and rental or purchase of medical equipment. 30 days or twice the days confined			
Hospice *(Initial)*	$1,000	$1,000	$1,000	$1,000
Hospice *(Daily)*	$50	$50	$50	$50
Maximum combined Initial and Daily per lifetime	$15,000	$15,000	$15,000	$15,000
Hospital Confinement *(30 days or less, per day)*	$100	$150	$250	$350
Hospital Confinement *(31 days or more, per day)*	$200	$300	$500	$700
Lodging *(per day)*	$50	$50	$75	$80
Maximum days per calendar year	70	70	70	70
Medical Imaging Studies *(per study)*	$75	$125	$175	$225
Maximum per calendar year	$150	$250	$350	$450
Outpatient Surgical Center *(per day)*	$100	$200	$300	$400
Maximum per calendar year	$300	$600	$900	$1,200
Private Full-time Nursing Services *(per day)*	$50	$75	$125	$150
Prosthetic Device/ Artificial Limb *(per device or limb)*	$1,000	$1,500	$2,000	$3,000
Maximum per lifetime	$2,000	$3,000	$4,000	$6,000
Radiation/Chemotherapy				
Injected chemotherapy by medical personnel *(one per week)*	$250	$500	$750	$1,000
Radiation delivered by medical personnel *(one per week)*	$250	$500	$750	$1,000
Self-Injected Chemotherapy *(one per month)*	$150	$200	$300	$400
Pump Chemotherapy *(one per month)*	$150	$200	$300	$400
Topical Chemotherapy *(one per month)*	$150	$200	$300	$400
Oral Hormonal Chemotherapy *(1-24 months)*, one per month	$150	$200	$300	$400
Oral Hormonal Chemotherapy *(25+ months)*, one per month	$75	$100	$150	$200

Cancer Assist (continued)

Benefits	Level 1	Level 2	Level 3	Level 4
Oral Non-Hormonal Chemotherapy *(one per month)*	$150	$200	$300	$400
Reconstructive Surgery *(per surgical unit)*	$40	$40	$60	$60
Maximum per procedure, including 25% for general anesthesia	$2,500	$2,500	$3,000	$3,000
Second Medical Opinion *(one per lifetime)*	$150	$200	$300	$300
Skilled Nursing Care Facility *(Per day up to the number of days for hospital confinement)*	$75	$100	$100	$150
Skin Cancer Initial Diagnosis *(one per lifetime)*	$300	$300	$400	$600
Supportive/Protective Care Drugs/ Colony Stimulating Factors *(per day)*	$50	$100	$150	$200
Maximum per calendar year	$400	$800	$1,200	$1,600
Surgical Procedures *(per unit)*	$40	$50	$60	$70
Maximum per procedure	$2,500	$3,000	$5,000	$6,000
Transportation *(per mile)*	$0.50	$0.50	$0.50	$0.50
Maximum per round trip	$1,000	$1,000	$1,200	$1,500
Additional Benefits				
Bone Marrow Donor Screening *(Maximum of one per lifetime)*	$50	$50	$50	$50
Cancer Vaccine Benefit *(Maximum of one per lifetime)*	$50	$50	$50	$50
Waiver of Premium	Yes	Yes	Yes	Yes
Health Screening Benefit *(Per covered person per calendar year)*	$100	$100	$100	$100

Sample Deductions

Sample CA Rates shown at the bottom includes $100 Health Screening. Cancer coverage is pretax eligible.

	Issue Age	Named Insured	Employee & Spouse	One-Parent Family	Two-Parent Family
Semi-monthly Rates (24 Pay Periods)					
Level 1	17-75	$9.33	$14.73	$9.40	$14.80
Level 2	17-75	$11.15	$17.43	$11.30	$17.58
Level 3	17-75	$13.73	$22.85	$13.95	$23.08
Level 4	17-75	$18.33	$30.58	$18.63	$30.88

Critical Illness 1.0

Colonial Life's individual Specified Critical Illness 1.0 insurance helps you and your family maintain financial security during the lengthy,expensive recovery period of a critical illness. It provides a lump sum benefit to help with the out-of-pocket medical and non-medical expenses of employees who suffer a critical illness.

Benefits	Description
Face Amount	Can choose anywhere from $5,000 face amount up to $30,000. Spouse receives 50% of employee's face amount. Children receive 25% of the employee's face amount.
For the diagnosis of this covered critical illness condition:	This percentage of the face amount is payable:
• Heart attack *(myocardial infarction)*	25% of Surgical Procedures Benefit
• Stroke	$25
• End-stage renal *(kidney)* failure	$25
• Major organ failure	$150
• Permanent paralysis due to a covered accident	$500
• Coma	$3,500
• Blindness	$3,500
• Coronary artery bypass graft surgery/disease	2
Additional Benefits:	**Description**
Subsequent Diagnosis Of A Critical Illness	If you receive a benefit for a specified critical illness, and later you are diagnosed with a different specified critical illness, the original percentage of the face amount is payable for that particular specified critical illness. If you receive a benefit for a specified critical illness, and later you are diagnosed with the same specified critical illness, 25% of the original face amount is payable
Maximum Benefit Amount	3x the face amount for the named insured for all covered persons combined. The policy will terminate when the maximum benefit amount for specified critical illness has been paid.
Health Screening Benefit Per covered person per calendar year	$50
Mammography Benefit	$200
Cervical Cancer Screening Test Benefit	$70

Sample Deductions

Sample CA Rates shown at the bottom includes Subsequent Diagnosis & Health Screening Benefits. Rates are based off non-tobacco. Critical Illness coverage is post-tax.

	Issue Age	Named Insured	Employee & Spouse	One-Parent Family	Two-Parent Family
Semi-monthly Rates (24 Pay Periods)					
$15,000	25-29	$4.65	$7.15	$4.65	$7.15
	30-34	$5.25	$8.13	$5.25	$8.13
	35-39	$7.05	$10.83	$7.05	$10.83
	40-44	$8.25	$12.63	$8.25	$12.63
	45-49	$10.50	$16.08	$10.50	$16.08
	50-54	$13.20	$20.28	$13.20	$20.28

Individual Medical Bridge 7000

Colonial Life's Individual Medical Bridge insurance can help with medical costs that your health insurance may not cover. These benefits are available for you, your spouse and eligible dependent children. Individual Medical Bridge coverage is pre-tax eligible.

Benefits	Description
Hospital Confinement Maximum of one benefit per covered person per calendar year	Can choose $1,000 or $1,500
Observation Room Visit Maximum of two visits per covered person per calendar year	$100 per visit
Rehabilitation Unit Confinement Maximum of 15 days per confinement with a 30-day maximum per covered person per year	$100 per day
Waiver of Premium Available after 30 continuous days of a covered hospital confinement of the named insured	Included
Medical Treatment Package	
• Air Ambulance	$1,000/day with a maximum of one day per covered person per calendar year
• Ambulance	$100/day with a maximum of one day per covered person per calendar year
• Appliance	$100/day with a maximum of one day per covered person per calendar year
• Doctor's Office Visit/Telemedicine	$25/day with a maximum of three days per calendar year for named insured only coverage; maximum of five days per calendar year for all covered persons combined for family coverage
• Emergency Room Visit	$100/day with a maximum of two days per covered person per calendar year
• X-Ray	$25/day with a maximum of two days per covered person per calendar year
Diagnostic Benefit This benefit contains two tiers of benefits and a calendar year maximum payable per covered person per calendar year for the specified diagnostic procedures.	Tier 1 - $250 Tier 2 - $500 Calendar Year Maximum - $500
Outpatient Surgery - Tier 1 Examples: Colonoscopy, Hemorrhoidectomy, Laparoscopic hernia repair, Tonsillectomy, Pacemaker insertion, Foot surgery *(bunionectomy, exostectomy, arthroplasty, hammertoe repair)*, Removal of tendon lesion	$500
Outpatient Surgery - Tier 2 Examples: Breast reconstruction, Breast reduction, Angioplasty, Cardiac catherization, Exploratory laparoscopy, Ethmoidectomy, Cataract surgery, Glaucoma surgery, Hysterectomy, Myomectomy, Arthroscopic knee surgery with meniscectomy *(knee cartilage repair), Dislocations & Fractures (open reduction with internal fixation)*, Tendon/ligament repair	$1,000
Maximum Outpatient Surgery Benefit Per covered person per calendar year for all covered	$1,500
Health Screening Benefit	$100
Additional Benefits:	**Description**
Daily Hospital Confinement Per covered person day of hospital confinement, maximum of 365 days per confinement	$100 per day
Enhanced Intensive Care Unit Confinement Per covered person per day of intensive care unit confinement, maximum of 30 days per confinement	$500 per day

Individual Medical Bridge 7000 (continued)

Sample Deductions

	Issue Age	Employee	Employee & Spouse	One-Parent Family	Two-Parent Family
Semi-monthly Rates (24 Pay Periods)					
$1,000 Hospital Confinement	17-49	$19.70	$36.83	$27.08	$44.20
	50-59	$24.70	$46.30	$32.08	$53.68
	60-64	$30.33	$57.00	$37.70	$64.38
	65-75	$37.30	$70.25	$44.68	$77.63

TermLife 5000

Colonial Life's Term Life insurance plan offers life insurance protection where the benefit remains the same through the life of the policy. At the end of the term period selected by the employee (10-, 15-, 20-, or 30-years), the policy maybe continued on a yearly renewable basis, without proof of good health.

Benefits	Description
Death Benefit Amounts available vary by age	Range from $10,000 to $250,000
Term Levels Varies by age, provides coverage for set amount of years with guaranteed level premiums and may be renewed annually thereafter without evidence of insurability	10, 15, 20, and 30-year terms available
Terminal Illness Accelerated Death Benefit Automatically included in the base policy at no additional premium, allows policy owner to receive an advance of up to 75% of face amount, up to a maximum of $150,000 *(in most states)*	Can request up to 75% of death benefit if diagnosed with a terminal illness has a life expectancy of 12 months or less
Additional Benefits:	**Description**
Spouse Term Rider Spouse signature not required, may convert to a cash value policy	Death benefits range from $10,000 to $50,000,10 and 20-year term options available
Children's Term Rider Covers all dependent children for one level premium, may convert to a cash value policy	Death benefits range from $1,000 to $20,000
Accidental Death Benefit Rider Up to a maximum of$150,000	Doubles benefit amount if insured dies as a result of an accident before age 70
Waiver of Premium Benefit Rider Total disability is considered permanent when the total disability continues with no interruptions for at least six consecutive months.	Waives all premiums due on the base policy & attached riders during the total and permanent disability of the primary insured before age 65

Sample Deductions

Sample Rates shown at the bottom are based off non-tobacco rates. Term Life coverage is post-tax.

Non-Tobacco Rates	10 Year Term				
	Issue Age	$25,000.00	$50,000.00	$75,000.00	$100,000.00
Semi-monthly Rates (24 Pay Periods)					
	30	$5.83	$5.11	$6.66	$8.21
	40	$6.98	$7.02	$9.53	$12.04
	50	$11.65	$12.79	$18.19	$23.58

Non-Tobacco Rates	20 Year Term				
	Issue Age	$25,000.00	$50,000.00	$75,000.00	$100,000.00
Semi-monthly Rates (24 Pay Periods)					
	30	$5.91	$5.27	$6.91	$8.54
	40	$7.29	$7.71	$10.56	$13.42
	50	$12.85	$15.79	$22.69	$29.58

Whole Life 5000

Colonial Life's Whole Life insurance plan is individually owned,with guaranteed level premiums,guaranteed cash values and a guaranteed death benefit. Coverage is permanent and is guaranteed for the life of the policy (to age 100), provided premiums are paid when due. Both Paid up at age 70 and Paid up at age 100 are represented.

Benefits	Description
Death Benefit Amounts available vary by age	$5,000 to $500,000
Two Plan Options The policy is paid-up at the original face amount when the insured reaches the specified age, with no additional premiums due	Paid-Up at Age 70 & Paid-Up at Age 100
Guaranteed Cash Value In addition to death benefit coverage, it also provides a guaranteed cash value accumulation that grows tax deferred.	4.5%
Terminal Illness Accelerated Death Benefit Automatically included in the base policy at no additional premium, up to a maximum of $150,000 *(in most states)*	Can request up to 75% of death benefit if diagnosed with a terminal illness and has a life expectancy of 12 months or less
Additional Benefits:	**Description**
Guaranteed Purchase Option Provides the policy owner the right to buy additional insurance on the life of the insured without providing evidence of insurability if the policy is purchased before age 55.	Available on the second, fifth, and eight anniversary dates.
Juvenile Whole Life Plan Employees can purchase this for children or grandchildren without purchasing coverage of themselves	A juvenile whole life plan is available for eligible dependents.
Spouse Term Rider Spouse signature not required, may convert to a cash value policy	Face amounts range from $5,000 to $50,000, 10 and 20-year term options available
Children's Term Rider Covers all dependent children for one level premium, may convert to a cash value policy	Face amounts range from $1,000 to $20,000
Accidental Death Benefit Rider Up to a maximum of$150,000	Doubles benefit amount if insured dies as a result of an accident before age 70
Waiver of Premium Benefit Rider Total disability is considered permanent when the total disability continues with no interruptions for at least six consecutive months.	Waives all premiums due on the base policy & attached riders during the total and permanent disability of the primary insured before age 65

Sample Deductions

Sample Rates shown at the bottom are based off non-tobacco rates. Term Life coverage is post-tax.

Non-Tobacco Rates	Paid up at Age 70				
	Issue Age	$25,000.00	$50,000.00	$75,000.00	$100,000.00
Semi-monthly Rates (24 Pay Periods)					
	30	$13.88	$23.73	$34.84	$45.96
	40	$21.05	$38.17	$56.50	$74.83
	45	$35.25	$67.92	$101.12	$134.33
	Paid up at Age 100				
Semi-monthly Rates (24 Pay Periods)					
	30	$12.50	$21.12	$30.91	$40.71
	40	$17.88	$31.69	$46.78	$61.88
	45	$27.76	$49.13	$72.94	$96.75

MASA - Medical Transport

MASA Medical Transport Solutions®

$14/MONTH

DID YOU KNOW?

25 MILLION PEOPLE
are sent to the emergency room through ground or air ambulance every year*.

Insurance companies may not cover all air and ground ambulance expenses which can result in in-network out-of-pocket costs.**

Ground ambulance out-of-network transportation costs may be even higher than in-network.

EMERGENT PLUS MEMBERSHIP BENEFITS

A MASA MTS Membership provides the ultimate peace of mind at an affordable rate for emergency ground and air transportation assistance expenses within the continental United States, Alaska, Hawaii, and while traveling in Canada, regardless of whether the provider is in or out of your group healthcare benefi ts network. After the group health plan pays its portion, MASA works with providers to make certain our Members have no out-of-pocket expenses~ for emergency ambulance transportation assistance and other related services.

Emergency Air Ambulance Coverage[1]
MASA MTS covers out-of-pocket expenses associated with emergency air transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Emergency Ground Ambulance Coverage[1]
MASA MTS covers out-of-pocket expenses associated with emergency ground transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Hospital to Hospital Ambulance Coverage[1]
MASA MTS covers out-of-pocket expenses that you or a dependent family member may incur for hospital transfers, due to a serious emergency, to the nearest and most appropriate medical facility when the current medical facility cannot provide the required level of specialized care by air ambulance to include medically equipped helicopter or fixed-wing aircraft.

Repatriation to Hospital Near Home Coverage[1]
MASA MTS provides services and covers out-of-pocket expenses for the coordination of a Member's non-emergency transportation by a medically equipped, air or ground ambulance in the event of hospitalization more than one hundred (100) miles from the Member's home if the treating physician and MASA MTS' Medical Director says it's medically appropriate and possible to transfer the Member to a hospital nearer to home for continued care and recuperation.

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MASA - Medical Transport (continued)

Medical Air Services Association, Inc. is doing business as MASA MTS with its principal place of business at 1250 S. Pine Island Road, Suite 500, Plantation, FL 33324. The information provided in this product information sheet is for informational purposes only. The benefits listed, and the descriptions thereof do not represent the full terms and conditions applicable for usage and may only be offered in some memberships. Premiums and benefits vary depending on the benefits selected. Please refer to the applicable member service agreement for a complete list of benefits, premiums, and full terms, conditions, and restrictions. MASA MTS utilizes third-party transportation service-providers for all transportation services. MASA Global, MASA MTS and MASA TRS are registered service marks of MASA Holdings, Inc., a Delaware corporation.

~If a member has a high deductible health plan that is compatible with a health savings account, benefits may become available under the MASA membership for expenses incurred for medical care (as defined under Internal Revenue Code ("IRC") section 213 (d)) once a member satisfies the applicable statutory minimum deductible under IRC section 223(c) for high-deductible health plan coverage that is compatible with a health savings account.

COVERAGE TERRITORIES:

1. United States and Canada Only – Emergency Air Ambulance Coverage, Emergency Ground Ambulance Coverage, and Hospital to Hospital Ambulance Coverage benefits shall only be provided in the United States and Canada.

SOURCES:
*CDC, 2022
** Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards. May 5, 2021.

MASA Medical Transport Solutions®

1250 S. Pine Island Rd., Suite 500,
Plantation, FL 33324

800-643-9023 I www.masamts.com

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MASA - Medical Transport (continued)

MASA Medical Transport Solutions®

$39/MONTH

DID YOU KNOW?

25 MILLION PEOPLE
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Insurance companies may not cover all air and ground ambulance expenses which can result in in-network out-of-pocket costs.**

Ground ambulance out-of-network transportation costs may be even higher than in-network.

PLATINUM MEMBERSHIP BENEFITS

A MASA MTS Membership provides the ultimate peace of mind at an affordable rate for emergency ground and air transportation assistance expenses within the continental United States, Alaska, Hawaii, and while traveling in Canada, regardless of whether the provider is in or out of your group healthcare benefi ts network. After the group health plan pays its portion, MASA works with providers to make certain our Members have no out-of-pocket expenses~ for emergency ambulance transportation assistance and other related services.

Emergency Air Ambulance Coverage[3]
MASA MTS covers out-of-pocket expenses associated with emergency air transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Emergency Ground Ambulance Coverage[3]
MASA MTS covers out-of-pocket expenses associated with emergency ground transportation to a medical facility for serious medical emergencies deemed medically necessary for you or your dependent family member.

Hospital to Hospital Ambulance Coverage[3]
MASA MTS covers out-of-pocket expenses that you or a dependent family member may incur for hospital transfers, due to a serious emergency, to the nearest and most appropriate medical facility when the current medical facility cannot provide the required level of specialized care by air ambulance to include medically equipped helicopter or fixed-wing aircraft.

Repatriation to Hospital Near Home Coverage[1]
MASA MTS provides services and covers out-of-pocket expenses for the coordination of a Member's non-emergency transportation by a medically equipped, air or ground ambulance in the event of hospitalization more than one hundred (100) miles from the Member's home if the treating physician and MASA MTS' Medical Director says it's medically appropriate and possible to transfer the Member to a hospital nearer to home for continued care and recuperation.

Patient Return Transportation Coverage[1]
MASA MTS provides services and covers the out-of-pocket expenses associated with coordinating a Member's transportation when hospitalized more than one hundred (100) miles from home, after discharge from the medical facility, by a regularly scheduled commercial airline to the commercial airport nearest the Member's home.

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MASA - Medical Transport (continued)

MASA Medical Transport Solutions®

$39/MONTH

PLATINUM MEMBERSHIP BENEFITS

Companion Transportation Coverage[2]
MASA MTS provides services associated with the coordination of transportation for the Member's spouse, other family member, or companion to accompany the Member's emergency transport by a medically equipped, rotary (i.e., helicopter) or fixed-wing aircraft, giving due priority to the medical personnel and/or equipment and the welfare and safety of the patient.

Hospital Visitor Transportation Coverage[2]
MASA MTS provides services and covers air transportation expenses associated with coordinating a round-trip, regularly scheduled, commercial airfare for Member's spouse, other family Member or companion to join the Member in the event of in-patient hospitalization more than one hundred (100) statute miles from Member's home.

Minor Return Transportation Coverage[2]
MASA MTS provides services and covers out-of-pocket expenses associated with minor return transportation to a parent, legal guardian, or another person that can be responsible for the minor in the event that the minor is unattended as a result of Member's Emergency Air or Ground Ambulance, Hospital to Hospital Ambulance, Repatriation to Hospital Near Home, or Mortal Remains Transportation coverages. MASA MTS also provides for a qualified attendant to accompany the minor during travel when the minor's age and/or medical condition may require such care.

Vehicle & RV Return Coverage[2]
MASA MTS provides services and covers the out-of-pocket expenses associated with vehicle return transportation for one (1) a safe operational car, truck, van, motorcycle, travel trailer, or motor home to the Member's home. This service is available when a Member uses Emergency Air or Ground Ambulance, Hospital to Hospital Ambulance, Repatriation to Hospital Near Home, Patient Return Transportation or Mortal Remains Transportation Coverages. MASA MTS pays the cost of fuel, oil and driver.

Pet Return Transportation Coverage[2]
MASA MTS provides services and covers out-of-pocket expenses for the return transportation to a Member's home for up to two (2) pet(s) belonging to the Member that includes either a dog, cat or other small animal(s). This service is available when a Member uses Emergency Air or Ground Ambulance, Hospital to Hospital Ambulance, Repatriation to Hospital Near Home, Patient Return Transportation or Mortal Remains Transportation Coverages.

Organ Retrieval & Organ Recipient Transportation Coverage[4]
MASA MTS provides services and covers air transportation expenses associated with coordinating transportation for an organ when the Member requires an organ transplant. MASA MTS will also provide service and cover transportation costs of Member and Member's spouse, other family Member or a companion should the Member need to travel to the location where the procedure will occur. If medically necessary, the organ will be transported by a medically equipped fixed-wing aircraft; otherwise, the organ is delivered by a commercial airline to the suitable airport nearest the location of the operation.

Mortal Remains Transportation Coverage[1]
MASA MTS covers the air transportation expense for a Member's mortal remains in the event of their death when it occurs more than one hundred (100) statute miles from home. Remains are transported by a regularly scheduled commercial airline to the commercial airport nearest a Member's home.

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MASA - Medical Transport (continued)

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Plantation, FL 33324

800-643-9023 I www.masamts.com

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masa

Why choose MASA?

MASA protects your finances and gives you compassionate support for medical transport.

When 1 in 15 families need an ambulance each year[1] and 79% of those rides may be out of network[2] – adding a layer of protection is critical.

MASA has been trusted for over 50 years and supports 2 million members globally.

Ground and air medical transports are covered nationwide — no network needed.

Specialized services for issues due to emergencies while traveling are available — like return transports for the patient, their pets, vehicles, and children.

MASA claims team is focused on paying, not denying, with an easy process — just send us the bill.

Enroll today!

Sources
1: Consumer Reports, 2021
2: Milliman data complied Dec. 2023

Employee Assistance Program (EAP)

Website: www.liveandworkwell.com

Access code: NevadaCA

Customer Service Number: 866-248-4096
Contract/Group Number: 9519227

Who provides the EAP?

OPTUM is a firm of select professionals who can help you with life's challenges. You will be referred to a conveniently located counselor or resource with expertise in your area of concern.

Counseling Visits

The EAP offers free short-term counseling visits for almost any personal issue. OPTUM EAP offers 5 face to face counseling visits per issue per year. Master's level employee assistance specialists will help you find a counselor or resource that will best fit your needs. OPTUM will work with you to find the most appropriate counselor to meet your needs.

- Marital/relationship issues
- Parenting/family issues
- Work concerns
- Depression
- Anxiety
- Stress
- Substance abuse
- Other issue impacting your quality of life

Work/Life Referrals

Work/Life consultants can provide you with referrals and information for services such as:

- Child care
- Elder care
- Pet care
- Adoption assistance
- School/college assistance
- Health and wellness
- Convenience referrals

Legal Consultation

Attorneys are available to answer your legal questions, either in-person or over the phone. Up to 30 minutes of free consultation per incident is provided. On-going services, if required, are offered at a discount. The EAP can assist with legal issues such as:

- Divorce
- Child custody
- Real estate
- Personal injury
- Criminal law
- Free sample will kits

Financial Consultation

The EAP offers telephonic consultation on a variety of important financial issues, including:

- Budgeting
- Debt management
- Financial planning
- First time home buyer program
- Tax questions
- Identity fraud service
- Free credit report/ review

Educational Resources

- Adult education classes
- Career consulting
- Home schooling
- Individual educational plans
- School and college recommendations

Sanvello

Providing you easy access to clinical techniques that can help with symptoms of stress, anxiety and depression at anytime. Visit LiveandWorkWell.com under popular tools to download the app.

Liveandworkwell.com

Access a wide range of self-help information and resources that include videos, personal empowerment programs and articles.

For more information, please call 866-248-4096 or visit optum.com.

OPTUM®

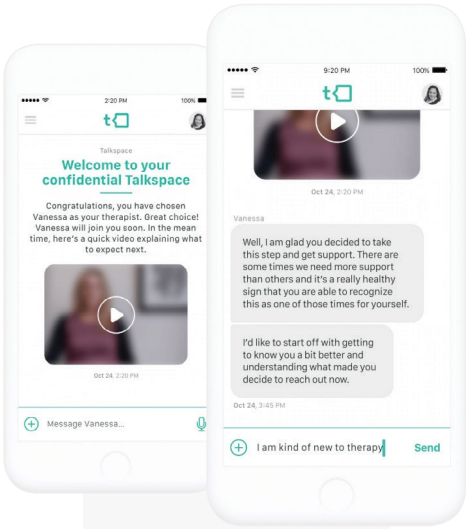
Support when you need it — no appointments necessary.

Now you can get the extra support you need in a way that works for you. With Talkspace, you can reach out to a licensed, in-network Employee Assistance Program Provider, 24/7.

Here's how Talkspace can fit your life:

- Access Talkspace anytime, anywhere.
- Find an EAP provider with an online matching tool.
- Start therapy within hours of choosing your EAP provider.
- Message your EAP provider whenever — no appointments necessary.
- Get messages back throughout the day, five days a week.
- Choose real-time face-to-face video visits by appointment, when needed.

talkspace



iOS • ANDROID • DESKTOP
MESSAGING • VOICE • VIDEO • PHOTO

To get started, call your Employee Assistance Program 1-866-248-4096 to obtain an authorization code prior to registering (first visit only), choose a provider, and message anywhere, anytime. **talkspace.com/connect**

After you register, download the Talkspace app on your mobile phone. Talkspace is supported by Chrome, FireFox, Safari or Edge browsers on your desktop computer.

Talkspace is *your* space. To use in *your* time. It's private, secure, confidential and convenient. And it's covered under your Employee Assistance Program benefits as a participating provider.

Flexible Spending Accounts (FSA)

Medical Expense Reimbursement/ Health Care Flexible Spending Account (FSA)

The County offers a tax-free benefit plan that provides you with ways to save up to thousands of dollars per year by offering the option to pay for certain types of expenses with pre-tax payroll deductions. If you choose to participate, this will reduce your taxable income.

What is the maximum I can elect?

For 2026, the maximum contribution amount is $3,400.

How do I use my FSA?

The Medical Expense FSA allows you to set aside tax-free dollars that will reimburse you for qualifying expenses incurred during the plan year. Qualified expenses include most medically necessary out- of-pocket medical, dental, and vision related expenses.

Can I be reimbursed through FSA for medical expenses incurred by my family members?

Yes! You may be reimbursed for qualified medical expenses incurred by your spouse, dependent child(ren) or domestic partner that is a federal tax dependent.

Your plan allows reimbursement for qualified expenses that you incur for an eligible adult child up to the age of 26.

The following is a sample of permitted expenses:

- Acupuncture
- Allergy treatments
- Chiropractic
- Contact lenses & supplies
- Dental (non-cosmetic)
- Doctor office visits & exams
- Glasses (prescription)
- Hearing aids
- Insulin & insulin supplies
- Insurance copays and deductibles
- Laboratory fees
- Therapy
- Psychiatric care
- Prescriptions (medically necessary)

Navia Benefit Solutions website:
https://www.naviabenefits.com/

Customer Service Number: 425-452-3500

Flexible Spending Accounts (FSAs) Termination and Claims Submission Deadlines

Please Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Dependent Care Flexible Spending Account (FSA)

The County offers a Dependent Care FSA option through Navia Benefit Solutions where you can set aside pre-tax dollars to cover dependent care expenses.

What is the maximum I can elect?

For 2026, the maximum contribution amount is $7,500 per household or $3,750 if married filing separately and is subject to prevailing legislation.

How do I enroll in the FSA plan?

You will make your Flexible Spending Account election during Open Enrollment each year. Make enrollment changes on BenefitBridge.

To find more information about the benefits offered through Navia check out the Online Benefits Academy at https://www.naviabenefits.com/employee-oe-solutions/ or on the web at https://www.naviabenefits.com/.

HRA, FSA, HSA numbers are reflected for the 2025 calendar year. 2026 amounts are not typically determined until after the release of the Benefit Guide. Employees making elections for the 2026 year should keep this in mind.

LegalShield/ID Shield

Legal and identity theft matters can strike anytime, don't get caught without protection!

Shield your identity, privacy and legal rights with LegalShield and IDShield.

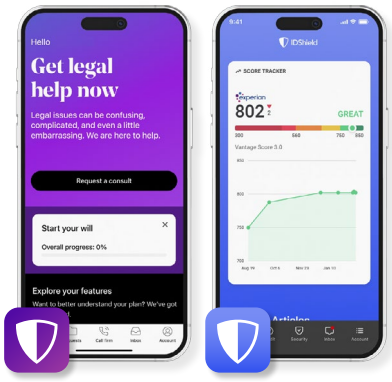
LegalShield

- Direct Access to your Own Provider Law Firm
- Unlimited Advice and Consultation
- Document Review and Preparation
- Divorce (up to 30 hours)
- Speeding Ticket Assistance
- Will Preparation
- Debt Collection Assistance
- Letters and Phone Calls Made on your Behalf

IDShield

- $3 Million Identity Fraud Protection Plan
- Online Privacy and Reputation Management
- Device Protection
- Financial Account Monitoring
- Identity, Credit and Social Media Monitoring
- Credit Score Tracker
- Real-Time Alerts

Always Connected.
Always Protected.



LegalShield
$26.00/monthly
Family Plan

IDShield

$7.45/monthly	**$14.05/monthly**
Employee Plan	Family Plan

LegalShield & IDShield

$32.45/monthly	**$38.05/monthly**
Employee Plan	Family Plan

Reduced rate pricing applies when enrolled in both plans.

For more information and to enroll, visit: **www.shieldbenefits.com/countyofnevada**

LegalShield
US

LegalShield/ID Shield (continued)

LegalShield®

Direct Access to a Dedicated Provider Law Firm
You will receive unlimited legal consultation and advice on personal legal matters. 100% of matters are covered in-network and your provider firm is even available 24/7 for covered emergencies.

Fast Response
An lawyer will respond to your legal matter within four business hours or less.

Letters And Phone Calls
Letters and phone calls can be made on your behalf to resolve legal matters such as warranty disputes or a dispute with a creditor.

Document Review And Preparation
A lawyer can help you review and prepare common legal documents for Wills, Trusts, and more.

Mobile App
The LegalShield mobile app allows you to call your provider law firm directly and makes it easy to upload and prepare documents for fast legal review.

Court Representation
You will receive representation for legal matters such as traffic tickets and even house closings.

Speeding Ticket Assistance
Your provider law firm will review your speeding ticket and even attend court on your behalf if required. You can easily upload your ticket using the LegalShield mobile app.

IDShield®

360˚ Degree Protection
IDShield monitors your identity, credit, financial accounts, social media accounts, and provides device and online privacy reputation management services.

Real-Time Alerts
If a threat is detected to your identity or credit you will receive an alert. You can view your alerts on the IDShield mobile app, member portal and receive them by email.

Device Protection
VPN Proxy One, password manager, online parental controls, anti-malware and mobile security.

Financial Protection
Financial account monitoring and a $3 Million Identity Fraud Protection Plan for unauthorized electronic fund transfers and identity theft related expenses.

Mobile App
The IDShield mobile app makes it easy for you to protect your identity and privacy and track your credit score with IDShield's monthly credit score tracker.

Privacy & Reputation Management
IDShield scans your social media accounts for content that could damage your reputation and provides ways to keep your online privacy safe.

Full-Service Restoration and Unlimited Consultation
If your identity is stolen, you get direct access to a Licensed Private Investigator who will restore your identity to its pre-theft status, guaranteed. You can also talk to an identity theft specialist about any identity theft or online privacy concern and get 24/7 emergency assistance.

Pre-Paid Legal Services, Inc. ("PPLSI") provides access to legal services offered by a network of provider law firms to its members through membership-based participation. Neither PPLSI nor its officers, employees or sales associates directly or indirectly provide legal services, representation, or advice. See a legal plan overview for specific state of residence for complete terms, coverage, amounts and conditions. IDShield provides access to identity theft protection and restoration services and plans are available at individual or family rates. A family plan covers the named member, named member's spouse or domestic partner and eligible dependent children under the age of 18. Consultation and Restoration Services or eligible dependent children under the age of 26. For complete terms, coverage, and conditions, please see an identity theft plan. All Licensed Private Investigators are licensed in the state of Oklahoma. An Identity Fraud Protection Plan ("Plan") is issued through a nationally recognized carrier. PPLSI is not an insurance carrier. This covers certain identity fraud expenses and legal costs as a result of a covered identity fraud event, with the amount of coverage dependent on the type of identity theft plan. See a Plan for complete terms, coverage, conditions, limitations, and family members who are eligible under the Plan.

US_BU_NP_LS+IDS_FS_EN_EnrollmentDivorce_v1_091823

US

MetLife Pet Insurance

MetLife | Pet Insurance

Security team. Workout partner. Best friend for life.

Help give them lifelong protection with MetLife Pet Insurance.

Help protect your pet from costly vet bills
More than ever, pets play such a huge role in our lives. We want to do everything to keep them safe and healthy. Help make sure your furry family members are protected against unplanned vet expenses for covered accidents or illnesses with MetLife Pet Insurance.

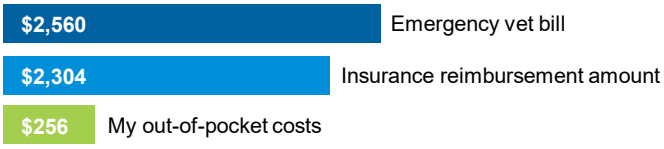
Visits to the vet can be unpredictable. According to 2022 Pet Parent Pulse Poll Findings, most pet parents are facing rising care costs to keep their pets happy and healthy, with 54% of owners worried about being able to care for their pets in the future with economic uncertainties.

A small monthly payment can help you prepare for those unexpected vet expenses down the road.

How it works:

Hypothetical savings example when visiting a licensed veterinarian, specialist or emergency clinic in the U.S.

Bella, a two-year-old mixed-breed dog, needed emergency surgery after swallowing some small rocks. Bella pulled through, but not until incurring an emergency vet bill of $2,560. Since I had MetLife Pet Insurance, I was reimbursed for 90% of the bill after the deductible was met. Thanks to my smart decision to enroll, I saved $2,304 in out-of-pocket vet expenses.[1]



With MetLife Pet Insurance, you can get:

- Flexible insurance plans
- Freedom to visit any U.S. veterinarian and be reimbursed up to 90%[2] of the cost of services
- Optional Preventive Care coverage[3]
- 24/7 access to Telehealth Concierge Services for immediate assistance
- Discounts up to 30%[4] and additional offers on pet care, where available
- Coverage of previously covered pre-existing conditions when switching providers

2023 PET INNOVATION AWARD

To enroll in these benefits, visit **www.metlife.com/getpetquote** or call **1-800-GET-MET8**.

MetLife Pet Insurance (continued)

MetLife | Pet Insurance

MetLife Pet Insurance can help take the worry out of covering the cost of unexpected pet care.

Product overview	Pet Insurance can help reimburse you for covered vet visits, accidents, illness and more. Plus, it can help keep your pet safe and healthy with optional Preventive Care Coverage.
Why needed	• Pet parents are spending more than $4,500 annually on pet care, according to 2021 Pet Wellness Month Survey Data • A small monthly payment can help plan for these expenses
Flexible coverage	Choose the plan that works for you and your pet. Options include: • Levels of coverage from $500–unlimited[5] • $0–$2,500 deductible options[6] • Reimbursement percentages from 50%–90%[2]
What is Covered	• accidental injuries • illnesses • exam fees • surgeries • medications • ultrasounds • hospital stays • X-rays and diagnostic tests
Coverage also includes	• hip dysplasia • hereditary conditions • congenital conditions • chronic conditions • alternative therapies • holistic care • and much more
Additional value	• Take your pet to any licensed veterinarian, specialist or emergency clinic in the U.S. • If you're claim-free in a policy year, we'll automatically decrease your deductible by $25 or $50[7] • Group discounts are available[8]

Hypothetical savings example when visiting a licensed veterinarian, specialist or emergency clinic in the U.S.[1]

Claim Details	Amount
Total vet bill (including exam, bloodwork, X-rays and hospitalization)	$1,278.00
Insurance reimbursement[2] percentage	90%
Out-of-pocket cost (including $100 deductible)	$227.80
Savings	$1,050.20

To enroll in these benefits, visit **www.metlife.com/getpetquote** or call **1-800-GET-MET8**.

Broadway Discounts

SAVE UP TO 20%*!
WITH BROADWAYSF
USE PROMO CODE: NEVADACOUNTY

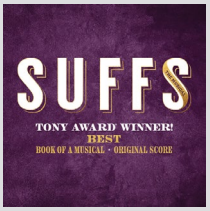
GET STARTED HERE

broadwaysf.com
888-746-1799

THEATRICALS

Sept 9–Oct 5 • CURRAN

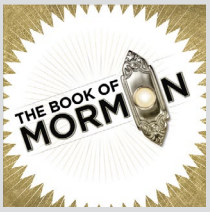
Sept 24–Oct 5 • ORPHEUM



Oct 21–Nov 9 • ORPHEUM

Oct 28–Nov 23 • CURRAN

Dec 16–28 • ORPHEUM
ON SALE AUG 8



Jan 13–Feb 1 • GOLDEN GATE
ON SALE AUG 22

FAMILY PROGRAMMING

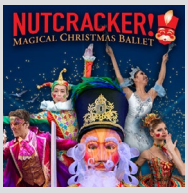
Aug 8–9
Davies Symphony Hall

Sep 21
Golden Gate

Oct 18
Curran

Nov 6
Golden Gate

Nov 22
Orpheum



Dec 17
Golden Gate

Visit **bit.ly/bsfcorpclub** for performance schedules and pricing

BRING A GROUP OF 10+ AND SAVE AN ADDITIONAL 10%
broadwaysf.com/tickets/group-sales

*Corporate pricing not available for all performances. Amount of savings varies between performance and seating section. All prices subject to change without notice.

ScholarShare529℠
WORKPLACE SAVINGS

Start saving more for your child's education

Nevada County

is proud to announce its new partnership with ScholarShare 529, a nationally-recognized college savings plan managed by TIAA-CREF Tuition Financing, Inc.

ScholarShare 529 is an industry leader with a 20-year track record of helping families like yours save to cover future college costs. Families appreciate the plan's special features including:

- **Tax benefits**
- **Low fees**
- **Flexibility**

Want more information?

Click the underlined links throughout this document for more information and resources.

- Can't make the *above* webinar? **Register for one of our live and interactive webinars that fits your schedule, hosted monthly.**
- **Schedule a consultation** with a 529 specialist.
- **Rollover an existing 529** into your ScholarShare 529 account. Schedule an appointment to have a consultant assist you.

Enroll anytime at ScholarShare529.com or call 800-544-5248.

ScholarShare529℠
WORKPLACE SAVINGS

POPULAR RESOURCES

Select your beneficiary

Choose your investment portfolio

Decide how much to save

Fund your account
- Periodic contributions
- Recurring contributions
- Workplace Savings

ADDITIONAL RESOURCES

Get started - step by step guide
Compare ways to save
College countdown
Frequently asked questions
Ugift
Informacion en Espanol
READYSAVE 529™

Download on the App Store | GET IT ON Google Play

Nationwide Deferred Compensation Plan

Put the power of time to work

Consider enrolling in Deferred Compensation

By contributing a little each payday to the Deferred Compensation Plan, you could benefit from investment earnings that compound over time.

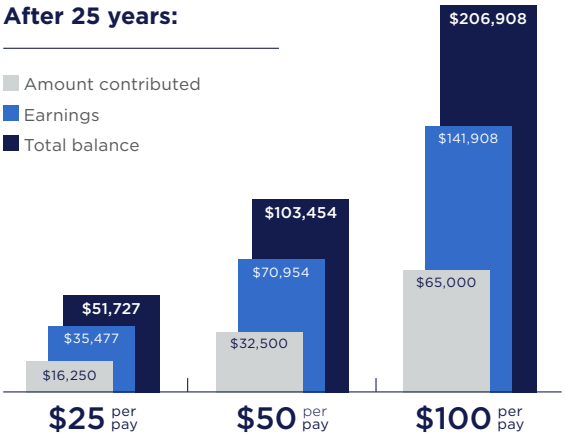
And it's easy to save! Plan participation offers:

- **Convenience** — Contributions are automatically deducted from your pay
- **A low entry point** — Contribute as little as $25 per pay
- **Flexibility** — Make changes whenever you want (subject to federal regulation)
- **Accessibility** — Manage your account 24/7/365 at nrsforu.com
- **Low cost** — As a governmental program, the Plan does not profit from your participation

Start building your savings now. **Enroll in your Deferred Compensation Plan today.**

This material is not a recommendation to buy or sell a financial product or to adopt an investment strategy. Investors should discuss their specific situation with their financial professional.

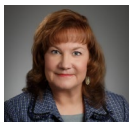
After 25 years:



This hypothetical illustration shows how much different deferral amounts per biweekly paycheck could accumulate over 25 years, assuming an 8% annual rate of return for an investor. This example is not a yield projection for any specific investment. If fees, taxes and expenses were reflected, the return would be less.

Scan this code to enroll online.

To schedule an individual appointment, scan this code.



Leanne Luttges
916-296-2149
l.luttges@nationwide.com

Retirement Resource Group
888-401-5272
nrforu@nationwide.com

NRM-7298M1.7 (04/25)

Nationwide

NACo

Perks at Work

perks at work

Perks That Matter

To help you live a better, happier life

Perks at Work is our FREE employee perks and discounts platform. Joining gives you access to 30,000 discounts and perks nation-wide. You can even invite friends and family to join in the savings!

Plus, receive free access to thousands of virtual courses through:

COA Community Online Academy

Simply log on to:

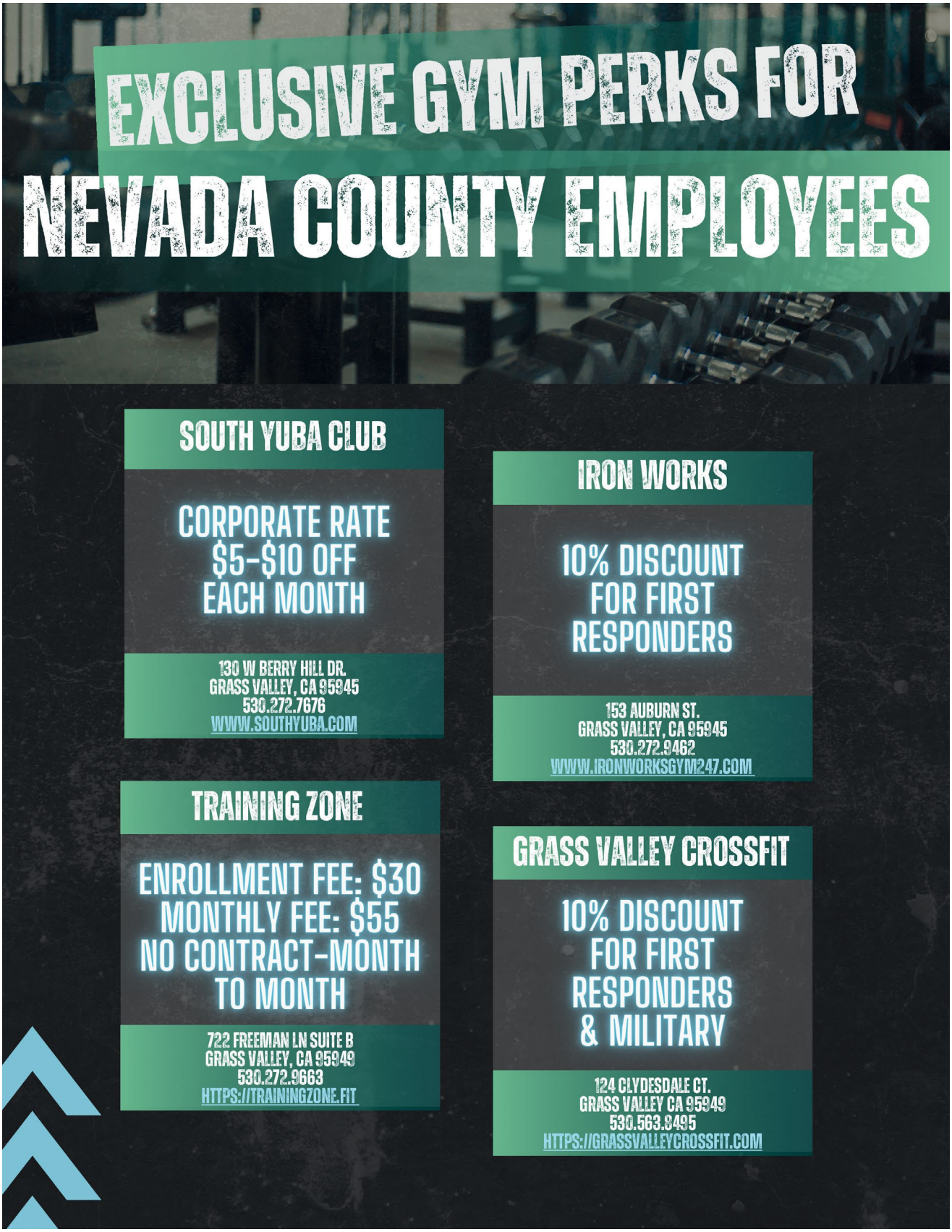
www.perksatwork.com

Click "Register for Free" and follow the instructions to activate your account.

TrueCar Columbia Lenovo Rosetta Stone

SAMSUNG HELLO FRESH talkspace

Employee Gym Discount



Enterprise Car Rental Discount

EMPLOYEE DISCOUNT ON CAR RENTALS

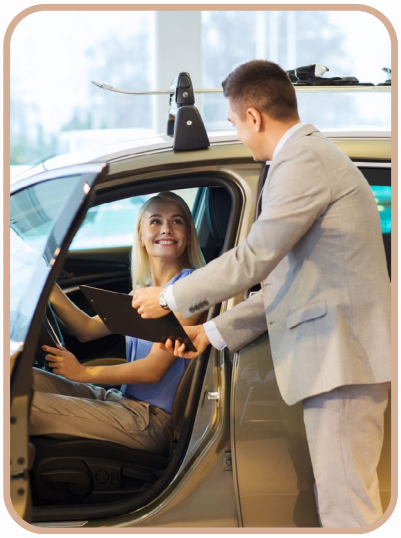
RESERVATION INFOMRATION

Log on to Enterprise Rent-A-Car's web site at **www.enterprise.com.**
Enter the Enterprise location where you would like to pick up your rental vehicle.
If you enter a ZIP code or city, you will be able to select the location to use on the next page.
Enter the Dates and Times of your desired reservation.
Enter your Account Number: XZPRCOU in the "Promotion Code or Account Number (Optional)" box and click on "Continue".
Enter your three-digit PIN: **/^P** number and click on "Continue".
At the next screen you can select your vehicle and click on "Continue".
The next screen will list any optional Equipment (such as a GPS unit) that is available at the requested location. Click "Continue to Review" once you are done selecting any additional equipment.
Next, you can review the location, dates, and vehicle type for the reservation. Scroll down to complete the "Renter Details"-please make sure to enter the information for the renter if you are booking the reservations for someone else.
After entering your personal information, enter your **"County Name and Department" in the additional information field. Click on "Reserve Now"** to finish your reservation.
You can also enter additional information in the "Save Time at the Counter" section to speed up the rental process.
You will be given a confirmation number for your reservation and a confirmation will be emailed to you.
You will need to have a valid Driver's License, Business ID/Badge or Business Card, Credit Card, and Reservation Number to pick up the vehicle.

Enterprise Car Rental Discount (continued)

ACCOUNT RULES

Personal use account can only be used by **current employees**
Retired or previous employees are not eligible to use this account
Reservations must be made under employee's name, **do not put a spouse or other family members name on the reservation**.
Rentals contracts must be written up in the employee's name using their valid driver's license and credit card.
We have the right to verify employment and cancel a reservation if employment cannot be verified
Please help us prevent fraud on this account: do not post this account information online
This document should only be posted on secure internal sites that only current employees can access



Important Notices

No Surprises Act Notice

Our medical plans are subject to the No Surprises Act, which limits the amount covered persons may have to pay for some out-of-network surprise medical bills. More information about surprise billing requirements included under the No Surprises Act and similar state laws can be found on the medical insurance company's website or the Plan Sponsor's website. Additional information may be found in your Explanation of Benefits for any affected claims.

Discrimination is Against the Law

County of Nevada complies with the applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including pregnancy, sexual orientation, gender identity, and sex characteristics). County of Nevada does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for a pregnancy hospital stay (for delivery) for a mother and her newborn may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply to this minimum length of stay. Early discharge is permitted only if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA) Annual Notice

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at 530.265.7070.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact Plan Administrator at 530.265.7070.

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

You do not need prior authorization from the plan or any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please contact Plan Administrator at 530.265.7070.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with CalPERS. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under covered medical, dental, and vision plans (the "Plan"). **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than their gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or,
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- The parent-employee dies;
- The parent-employee's employment ends for any reason other than their gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or,
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified of a Qualifying Event:

- The end of employment or reduction of hours of employment;
- Death of the employee; or,
- The employee becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if part of the employer's plan), are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, or as otherwise permitted by the COBRA administrator, no later than the date specified in the election form, and properly submitted to the Plan Administrator.

Each notice must include all of the following items: the covered employee's full name, address, phone number, and Social Security Number; the full name, address, phone number, and Social Security Number of each affected dependent, as well as each dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration's written disability determination, if applicable; and the name of the Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the employer or Plan Administrator.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their dependent children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This disability would have to have started some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. (See Notice and Election Procedures.)

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation of coverage, for a maximum of 36 months, if the Plan is properly notified about the second Qualifying Event. This extension may be available to the spouse and any dependent children receiving COBRA continuation of coverage if the employee or former employee dies; becomes entitled to Medicare (Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second Qualifying Event would have caused the spouse or the dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. (See Notice and Election Procedures.)

OTHER OPTIONS BESIDES COBRA CONTINUATION COVERAGE

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

ENROLLMENT IN MEDICARE INSTEAD OF COBRA

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information, visit https://www.medicare.gov/medicare-and-you.

IF YOU HAVE QUESTIONS

For more information about the Marketplace, visit www.healthcare.gov.

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), has jurisdiction with respect to the COBRA continuation coverage requirements of the Public Health Service Act (PHSA) that apply to state and local government employers, including counties, municipalities, public school districts, and the group health plans that they sponsor (Public Sector COBRA). COBRA can be a daunting and complex area of federal law. If you have any questions or issues regarding Public Sector COBRA, you may contact the Plan Administrator or email HHS at phig@cms.hhs.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for non-COBRA beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee, organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

[1] http://www.socialsecurity.gov/

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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 (including your spouse) for up to 24 months while in the military. Even if you do not 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 for pre-existing conditions except for service-connected injuries or illnesses.

Flexible Spending Accounts (FSAs) – Termination and Claims Submission Deadlines

Note: If you lose eligibility for any reason during the Plan Year, your contributions to your Health and/or Dependent Care FSAs will end as of the date your eligibility terminates. You may submit claims for reimbursement from your FSAs for expenses incurred during the Plan Year prior to your eligibility termination. You must submit claims for reimbursement from your Health and/or Dependent Care FSAs no later than 90 days after the date your eligibility terminates. Any balance remaining in your FSAs will be forfeited after claims submitted prior to this date have been processed.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

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 this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or the Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and/or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination to remain eligible for such assistance.

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death, or a Qualified Medical Child Support Order, you may be able to enroll yourself and/or your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption, or placement for adoption or divorce (including legal separation and annulment).

For information about Special Enrollment Rights, please contact:

Human Resources
530.2656.7010

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

County of Nevada Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources 530.2656.7010.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about County of Nevada in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget by offering "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away.

Open Enrollment for health insurance coverage through Covered California begins on November 1 of each year and ends on January 31 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.coveredca.com, KeenanDirect at 855-653-3626 or www.KeenanDirect.com.

Open Enrollment for most other states begins on November 1 and closes on January 15 of each year. For more information on Open Enrollment and other opportunities to enroll, visit www.healthcare.gov.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not "Affordable," or does not provide "Minimum Value." If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.96% (for 2026) of your household income for the year, then that coverage for you is not Affordable. Affordability for dependent family members is determined separately and is based on the total cost of family coverage. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's medical plan. If you receive premium savings for Marketplace coverage, the IRS may seek reimbursement of those funds.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered medical coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

STATES WITH INDIVIDUAL MANDATE

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/Rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855-653-3626 or at www.KeenanDirect.com. The information is numbered to correspond to the Marketplace application.

3. Employer name County of Nevada	**4. Employer Identification Number (EIN)** 94-6000526	
5. Employer address 950 Maidu Avenue	**6. Employer phone number** 530.265.7010	
7. City Nevada	**8. State** CA	**9. ZIP code** 95959
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	**12. Email address** human.resources@nevadacountyca.gov	

As your employer, we offer coverage that meets the minimum value standard to the employees as described in this Guide. The coverage offered to you meets the minimum value standard and the cost of this coverage to you is intended to be affordable based on employee wages.

Notice of Creditable Coverage: Information About Medicare Part D and Your Prescription Drug Coverage

County of Nevada has determined that the prescription drug coverage offered by the CalPERS plan is, on average for all plan participants, expected to pay out the same or more than what the standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

Please read this notice carefully and keep it where you can find it. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. NOTE: You are responsible for providing this notice to all Medicare eligible family members (or those about to become Medicare eligible).

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

When someone first becomes eligible to enroll in a government-sponsored Medicare "Part D" prescription drug plan, enrollment is considered timely if completed by the end of his or her "Initial Enrollment Period" which ends three months after the month in which he or she turned 65.

Unfortunately, if you choose not to enroll in Medicare Part D during your Initial Enrollment Period, when you finally do enroll, you may be subject to a late enrollment penalty added to your monthly Medicare Part D premium. Specifically, the extra cost, if any, increases based on the number of full, uncovered months during which you went without either Medicare Part D or without "Creditable" prescription drug coverage from another plan, such as our plan.

Eligible individuals can enroll in a Medicare Part D prescription drug plan during Medicare's "Annual Coordinated Election Period" (a.k.a. "Open Enrollment Period") running from October 15 through December 7 of each year, as well as during what is known as a "Medicare Special Enrollment Period" which is triggered by certain qualifying events, including the loss of creditable group prescription drug coverage. Those who miss these opportunities are generally unable to enroll in a Medicare Part D plan until another enrollment period becomes available. Finally, please be cautioned that even if you elect our coverage, you could be subject to a payment of higher Part D premiums if you subsequently experience a break in coverage of 63 continuous days or longer before you enroll in the Medicare Part D plan. Carefully coordinating your transition between plans is therefore essential.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current County of Nevada coverage will not be affected. If you keep this coverage and elect Medicare, the County of Nevada coverage will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current CalPERS coverage, be aware that you and your dependents may be unable to get this coverage back.

It is important for those eligible for both Medicare and our group health plan to look ahead and weigh the costs and benefits of the various options on a regular, if not annual, basis. Based on individual facts and circumstances, some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, please note that benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would reduce their payment to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

If you are Medicare eligible and 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 creditable coverage. For example, if you go 19 months without creditable coverage, your premium may be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) the entire time you have Medicare prescription drug coverage.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

If you have questions about your Medicare eligibility or how you can get help to pay for it, you can call the Social Security Administration at 1-800-772-1213 or visit www.socialsecurity.gov.

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, dial 1-877-KIDS-NOW, or visit 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 with paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility.

ALABAMA - Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA - Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS - Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (1-855-692-7447)

CALIFORNIA - Medicaid
Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 1-916-445-8322
Fax: 1-916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/chp
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA - Medicaid
Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

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

INDIANA - Medicaid
Website: https://www.in.gov/medicaid/ or
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid & CHIP (Hawki)
Medicaid Website: https://hhs.iowa.gov/medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program
HIPP Phone: 1-888-346-9562

Important Notices (continued)

KANSAS - Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPAA Phone: 1-800-967-4660

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

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

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

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

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

MISSOURI - Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA - Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

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

NEVADA - Medicaid
Medicaid Website: https://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

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

NEW JERSEY - Medicaid & CHIP
Medicaid Website:
https://www.nj.gov/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 1-609-631-2392
CHIP Website: https://njfamilycare.dhs.state.nj.us/
CHIP Phone: 1-800-701-0710 (TTY 711)

NEW YORK - Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA - Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 1-919-855-4100

NORTH DAKOTA - Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA - Medicaid and CHIP
Website: http://www.insureoklahoma.org/
Phone: 1-888-365-3742

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

PENNSYLVANIA - Medicaid & CHIP
Website: https://www.pa.gov/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND - Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA - Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

Important Notices (continued)

TEXAS - Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

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

VERMONT - Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA - Medicaid & CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON - Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA - Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 1-304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN - Medicaid & CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING - Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Glossary of Health Terms

Brand-Name Drug: FDA-approved prescription drugs marketed under a specific brand name by the manufacturer.

COBRA: This federal law allows employees and dependents who are enrolled in an employer-sponsored plan to temporarily continue receiving health coverage after certain qualifying events like termination or divorce.

Coinsurance: Coinsurance refers to the amount of money that a member is required to pay for healthcare services after any required deductible has been paid. Coinsurance is specified by a percentage. For example, the employee pays 15% toward the charges for a covered service and the insurance company pays 85%.

Copay: The flat fee you pay each time you utilize a healthcare service or fill a prescription.

Deductible: The specified amount you must pay for healthcare in a plan year before the plan will begin to cover all or a portion of your costs. Some plans have no deductible.

Dependent: A family member or other individual who meets the eligibility criteria established by the County for enrollment in an available healthcare plan.

Effective Date: The actual date your healthcare coverage is scheduled to begin. You are not covered until the effective date.

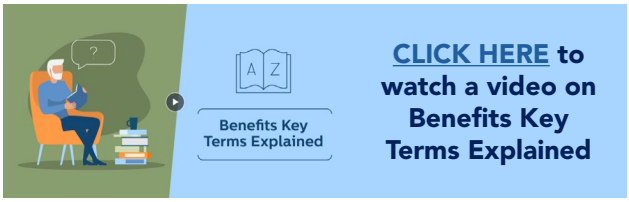
Employee Premium Contribution: The amount you must pay toward the cost of your health plan premiums.

Employer Premium Contribution: The amount your employer pays toward the cost of your health plan premiums.

Employer-subsidized Benefits: Benefits that are paid for, all or in part, with money contributed by the employer.

Enrollee: Individual enrolled in a health plan.

Explanation of Benefits (EOB): Written, formal statement sent to PPO enrollees that lists the services provided, amounts paid and costs billed by the health plan.



CLICK HERE to watch a video on Benefits Key Terms Explained

Evidence of Coverage (EOC): The Evidence of Coverage is a legal document that gives details about plan benefits and exclusions and how to get the care you need. It explains your rights, benefits and responsibilities as a member of your plan and the plan providers' responsibilities to you.

Exclusions: The list of conditions, injuries, or treatments that are not covered under your health insurance policy. Exclusions can be found in your plan document called the Evidence of Coverage.

Flexible Spending Account (FSA): An account that you contribute to pre-tax and that reimburses you for qualified healthcare and dependent care expenses.

Formulary: A comprehensive list of prescription drugs that are covered by a medical plan. The formulary is designed to assist physicians in prescribing drugs that are medically necessary and cost-effective for members. The formulary is updated periodically.

Generic Drug: FDA-approved prescription drugs that are a therapeutic equivalent to the brand-name drug, contain the same active ingredient as the brand-name drug, and cost less than the brand-name drug equivalent.

Health Maintenance Organization (HMO): An entity that provides health services through a closed network. Unlike PPOs, HMOs either employ their own staff or contract with groups of providers. HMO participants typically need pre-approval from a primary care provider before seeing a specialist.

Imputed Income: Federal IRS regulations require that the value of non-cash compensation, such as an employer's contribution to the health insurance of an employee's domestic partner, be reported as taxable income on federal returns.

In-Network: These providers or facilities are contracted with a health plan to provide services at pre-negotiated fees. Enrollees usually pay less when using an in-network provider, because these networks provide services at lower cost to the insurance companies with which they have contracts.

Glossary of Health Terms (continued)

Medical Group: An independent group of physicians and other healthcare providers that contract to provide services to members of an HMO.

Lifetime Maximum Benefit: The maximum amount a health plan will pay in benefits to an insured individual during that individual's lifetime.

Member: An employee or retiree designated as the primary plan subscriber, per the County's rules.

Non-Formulary Drug: A drug that is not on the insurer's list of approved medications. Non-formulary drugs can usually only be prescribed with a physician's special authorization.

Open Enrollment: The period of time when you can change your health benefit elections without a qualifying event.

Out-of-Area: A location outside the geographic area covered by a health plan's network of providers.

Out-of-Network: Providers or healthcare facilities which are not in your health plan's provider network. Some plans do not cover out-of-network service costs. Others charge a higher copay for this type of service.

Out-of-Pocket Costs: The actual costs you pay, including premiums, copays and deductibles for your healthcare.

Out-of-Pocket Maximum: The amount of money that an individual must pay out of their own pocket before an insurance company will pay 100% for an individual's healthcare expenses.

Point of Service (POS): Point of service insurance is one of three types of managed healthcare plans available in the United States. This type of healthcare plan combines features from the other two plans, the HMO (Health Maintenance Organization) and PPO (Preferred Provider Organization).

Preferred Provider Organization (PPO): An entity that contracts to provide healthcare services to subscribers at negotiated, often discounted, rates.

Premium: The amount charged by an insurer for healthcare coverage. This cost is usually shared by the employer and employee.

Primary Care Physician (PCP): The doctor (or nurse practitioner) who coordinates all of your medical care and treatment. HMOs require all plan participants be assigned to a PCP.

Qualifying Event: A change in your life situation that allows you to make a change in your benefit elections outside Open Enrollment. This includes marriage, domestic partnership, separation, divorce or dissolution of partnership, birth or adoption of a child, death of a dependent as well as obtaining or losing other healthcare coverage.

Reasonable and Customary Charges: The average fee charged by a particular type of healthcare practitioner within a geographic area. Often used by medical plans as the amount of money they will pay for a specific test or procedure. If the fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference.

Contact Information

Human Resources/Benefits Office

Questions regarding eligibility, enrollment, and deduction amounts should be directed to human.resources@nevadacountyca.gov

Payroll Resources

Questions regarding accuracy, adjustments, and statutory deductions should be directed to human.resources@nevadacountyca.gov

SharePoint

Benefit information and forms can be located on the County's intranet, SharePoint: https://nevcounty.sharepoint.com/

Employee Benefits Program	Group Number	Phone Number	Website/Email
Medical			
• CalPERS		888-225-7377	my.calpers.ca.gov https://www.calpers.ca.gov/members/health-benefits/plans-and-rates
• Anthem Blue Cross *(Basic HMO)*		855-839-4524	https://www.anthem.com/ca/mcr/calpers
• Blue Shield of California *(Basic HMO)*		800-334-5847	https://www.blueshieldca.com/group/calpers/
• Kaiser Permanente (HMO)		800-305-1220	https://choose.kaiserpermanente.org/calpers
• Blue Shield of California *(PERS Platinum/PERS Gold (PPO)*		855-633-4436	https://includedhealth.com/microsite/calpers/
• UnitedHealthcare *(Basic HMO)*		877-359-3714	https://www.whyuhc.com/calpers
• Western Health Advantage (HMO)		888-942-7377	https://www.westernhealth.com/calpers/plans-and-benefits/
• Medicare	N/A	800-633-4227	medicare.gov
• Social Security	N/A	800-772-1213	ssa.gov
Dental			
• Ameritas Dental	010-302140	800-487-5553	www.ameritas.com
Vision			
• Ameritas Vision (VSP)	010-302140	800-487-5553	www.ameritas.com www.vsp.com
Section 125			
• Navia Benefit Solutions Health Care FSA & Day Care FSA		425-452-3500	https://www.naviabenefits.com/
Life and Disability Insurance			
• Voya – Life Insurance & Disability Insurance *(Long & Short Term)*	716405	800-955-7736	www.voya.com
Employee Assistance Program (EAP)			
• OPTUM EAP	9519227	866-248-4096	www.optum.com
Voluntary			
• Building Blocks-Colonial	N/A	844-624-1380	westservice@bbforb.com
BenefitBridge	N/A	800-814-1862	benefitbridge@keenan.com
CalPERS Resources	N/A	Member Services: 888-225-7377	https://www.calpers.ca.gov/page/home
• Health Plan Zip Code			https://www.calpers.ca.gov/page/active-members/health-benefits/plans-and-rates/zip-search
• Health Program Guide			https://www.calpers.ca.gov/docs/forms-publications/health-program-guide.pdf
• Health Benefit Summary			https://www.calpers.ca.gov/documents/2026-health-benefit-summary/download?inline