Health Plan of San Joaquin

Mountain Valley Health Plan

2027 GUIDE TO Employee Benefits



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This Benefits Decision Guide provides an overview of the benefits and contributions available to all full-time employees working 30+ hours a week. All part-time employees working 20+ hours a week will experience different contributions. It should not be relied on as a binding legal document. In the event of any discrepancy, the official plan documents will govern in all cases.

Questions?

Health Plan of San Joaquin is ready to help you understand your options and make the right choices for your needs and budget.

Email: benefits@hpsj.com

Want more detailed information on your plans?

You can access your 2027 benefit summaries, SBCs and flyers at www.workforcenow.adp.com or HPSJ's internal SharePoint.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the creditable prescription drug coverage and Medicare notice in the legal notices at the back of this booklet for more details.



Welcome to Your 2027 Benefits!

Health Plan of San Joaquin/Mountain Valley Health Plan is committed to providing our employees with a comprehensive and competitive benefits program. Our objective is to offer an employee benefits program that delivers high quality healthcare at an affordable price.

The 2027 Benefits Decision Guide has been designed to assist you in determining the coverage levels that will provide you and your family with the protection that gives you peace of mind. We strongly recommend that you take the time to review this guide prior to enrolling.

To supplement this high-level overview of your benefits, we encourage you to refer to the detailed plan summaries and flyers posted in ADP.

Changes After Enrollment:

- You can make changes to some of your benefits in 2027 if you experience a Qualifying Life Event (QLE) outside of your enrollment window. You must make the change within 30 days of the event date. Please note: Supporting Documentation is required for each (QLE) request.
- If you are a New Hire or experience a QLE during or after November 2–13, 2026, you will need to update your 2026 and 2027 benefits by following the links for each year on ADP.

Enrolling Is Easy

Learn:

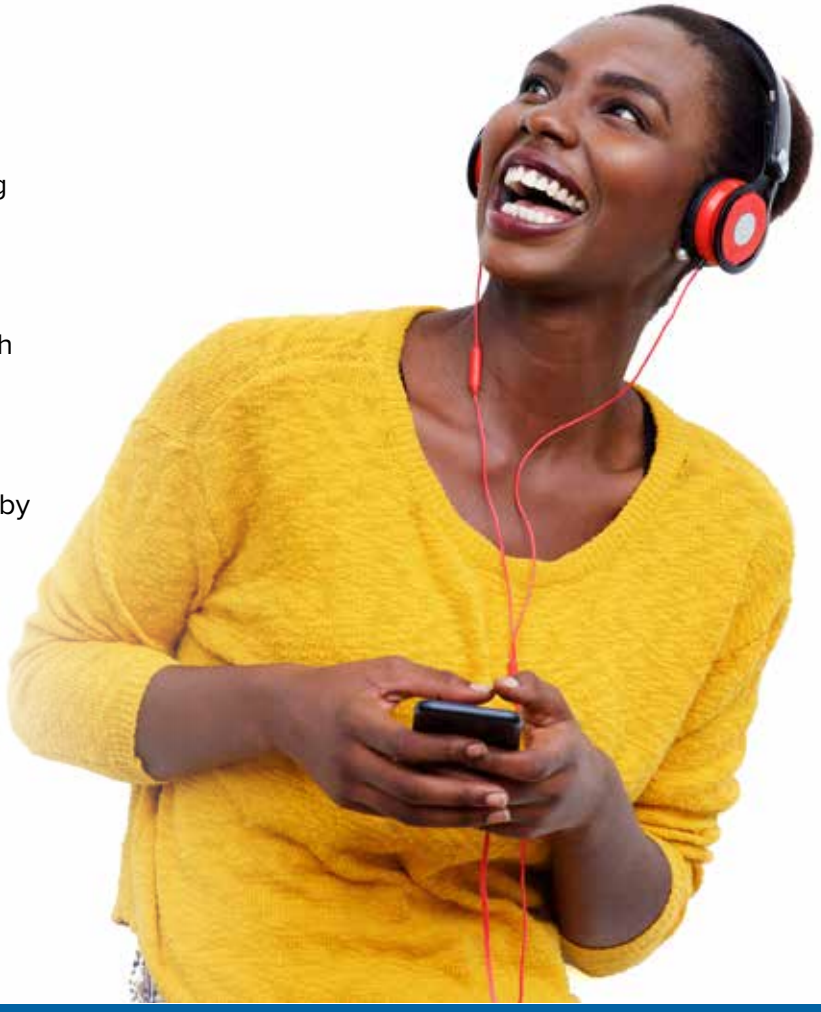
Understand your 2027 benefit options.

Decide:

Select the benefits that will provide the right coverage for you and your eligible dependents.

Enroll:

Log in to www.workforcenow.adp.com to make your 2027 elections.





Medical and Prescription Drug Coverage

Medical coverage offers valuable benefits to help you stay healthy and pay for care if you or your covered family members become sick or injured.

Which Medical Plan Is Right for You?

You will have six medical options to consider as you select your benefits.

As you prepare, think about:

- How much healthcare and what type of care did you need this year?
- Do you expect your needs to be similar next year?
- Do you prefer to pay less from your paycheck or less out of your pocket when you need care?

Key Words to Know:

- **Coinsurance:** Percentage of the charge you will pay, typically after you have met the deductible
- **Copay:** An amount you pay for a covered service each time you use that service, which usually does not apply toward the deductible
- **Deductible:** The amount you pay before the plan begins to pay
- **Out-of-Pocket Costs:** Expenses you pay, such as deductibles, copays and the remaining amounts after plan coinsurance is paid
- **Out-of-Pocket Maximum:** The maximum amount you pay for covered services in a year (you may need to pay additional amounts if you receive care from an out-of-network provider)

Need More Coverage?

You may want additional coverage that pays benefits directly to you to help cover deductibles and out-of-pocket expenses.

Consider combining your medical coverage with Supplemental Medical insurance from Unum. These plans are a great complement to your medical plans and can help reduce the financial risk associated with illness, injury or hospitalizations.

Depending on your situation, you may be able to save money by purchasing a lower cost medical plan and adding one or more supplemental plans to achieve effective protection at a lower plan cost. Refer to the Supplemental Medical section for more information.

Critical Illness

Accident

Hospital Indemnity

Using In-Network Providers

You'll save money when receiving care from an in-network provider. Using an out-of-network provider could result in more out-of-pocket costs.

Helpful Information About Deductibles and Out-of-Pocket Maximums

PLAN	DEDUCTIBLE	OUT-OF-POCKET MAXIMUM
All Plans	Once one family member meets the Individual Deductible, benefits begin to be paid for that individual.	Once one family member meets the Individual Out-of-Pocket Maximum, the plan pays covered benefits in full for that individual.

Prescription Drug Coverage

- Your prescription drug coverage depends on the medical plan you choose. Medications are grouped into tiers, which determine your portion of the drug cost.
- The applicable copay or coinsurance per prescription applies.

TIER*	YOU PAY	WHAT'S COVERED*
1	**Lowest Cost Sharing**	**Generic Prescription Drugs** Generic drugs that are equivalent to a brand product in dosage form, strength, quality and intended use
2	**Second-Lowest Cost Sharing**	**Preferred Brand Name Drugs** Drugs sold under specific trade names that are favorably priced by the pharmacy plan
3	**Second-Highest Cost Sharing**	**Non-Preferred Brand Name Drugs** Drugs sold under specific trade names that have a more cost-effective alternative compared to the lowest or the second-lowest cost sharing
4	**Highest Cost Sharing**	**Specialty Drugs** Specialty medications treat rare or complex conditions and are typically higher cost medications. Most will require pre-authorization before your plan will help pay for them, and some may require you to fill the prescription at a specialty pharmacy.

**Some plans have additional prescription tiers. See plan documents for details.*

Review Your Medical Plan Options

Aetna

OAMC (Open Access Managed Choice) – POS | Network – HMO

Aetna OAMC $2,000 | Aetna HMO $750

Medical Plan Summary

The following benefits are included in your plan options. Unless otherwise noted, benefits are per insured person and after deductible.

	AETNA OAMC $2,000		AETNA HMO $750
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK
ANNUAL DEDUCTIBLE			
Individual	$2,000	$4,000	$750
Family	$4,000	$8,000	$2,250
OUT-OF-POCKET MAXIMUM			
Individual	$5,000	$10,000	$5,000
Family	$10,000	$20,000	$15,000
MEDICAL BENEFIT COVERAGE			
Plan Coinsurance	20%	50%	0%
Preventive Care	Covered at 100%	50%	Covered at 100%
Primary / Specialist Visit	$30* / $50*	50%	$35* / $55*
Inpatient Hospital	20%	50%	$750/day for 3 days max, thereafter Covered 100%; after deductible
Outpatient Hospital	20%	50%	$250 copay; after deductible
Urgent Care	$50*	50%	$75*
Emergency Room	$300, then 20%		$250; after deductible
PRESCRIPTION DRUG DEDUCTIBLE			
Individual	$200	Not Covered	None
Family	$400	Not Covered	None
RETAIL PRESCRIPTIONS (30-DAY SUPPLY)			
Generic	$10*	Not Covered	$10*
Preferred Brand	$30	Not Covered	$30*
Non-Preferred	$55	Not Covered	$50*
Specialty	30% up to $250	Not Covered	30% up to $250
MAIL-ORDER PRESCRIPTIONS (90-DAY SUPPLY)			
Generic	$20*	Not Covered	$20
Preferred Brand	$60	Not Covered	$60
Non-Preferred	$110	Not Covered	$100
Specialty	Not Covered	Not Covered	Not Covered

**Deductible does not apply.*

Kaiser Permanente

Kaiser Permanente California Network – HMO

Kaiser DHMO Plan | Kaiser HMO Plan

Medical Plan Summary

The following benefits are included in your plan options. Unless otherwise noted, benefits are per insured person and after deductible.

	KAISER DHMO PLAN		KAISER HMO PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE				
Individual	$750	Not Covered	$0	Not Covered
Family	$1,500	Not Covered	$0	Not Covered
OUT-OF-POCKET MAXIMUM				
Individual	$3,000	Not Covered	$500	Not Covered
Family	$6,000	Not Covered	$1,000	Not Covered
MEDICAL BENEFIT COVERAGE				
Plan Coinsurance	20%; after deductible	Not Covered	0%	Not Covered
Preventive Care	Covered at 100%*	Not Covered	Covered at 100%	Not Covered
Primary / Specialist Visit	$30* / $40*	Not Covered	$15 / $25	Not Covered
Inpatient Hospital	20%; after deductible	Not Covered	$125	Not Covered
Outpatient Hospital	20%; after deductible	Not Covered	$50	Not Covered
Urgent Care	$30*	Not Covered	$15	Not Covered
Emergency Room	20%; after deductible		$50	
RETAIL PRESCRIPTIONS (30-DAY SUPPLY)				
Generic	$15	Not Covered	$5	Not Covered
Brand Name Items	$35	Not Covered	$10	Not Covered
Specialty	Same as Preferred	Not Covered	Same as Preferred	Not Covered
MAIL-ORDER PRESCRIPTIONS (90-DAY SUPPLY)				
Generic	$30	Not Covered	$10	Not Covered
Brand Name Items	$70	Not Covered	$20	Not Covered
Specialty	30% up to $250	Not Covered	Same as Preferred	Not Covered

**Deductible does not apply.*



Spending Accounts

Save money on your healthcare and dependent care costs through the use of a tax-advantaged account that allows you to use before-tax dollars to pay for eligible expenses.

Access Your Accounts Anywhere

The WEX mobile app is available for Healthcare Flexible Spending Accounts (FSA) and Dependent Care Flexible Spending Accounts. Use it to view account balances, upload receipts, review plan details, see your account activity and contact customer service.

Download the app from the App Store or Google Play. Once downloaded, you will log in with your spending account username and password you created when you opened your account.

What Are Eligible Healthcare Expenses?

For a complete list of eligible expenses, visit https://www.irs.gov/forms-pubs/about-publication-502 and see Publication 502. Some examples may include:

- Office visits
- Prescription drugs
- Hospital stays
- Speech/occupational/physical therapy
- Dental and vision care
- Lab work

Reminder: Keep documentation to support your use of the money in these accounts for tax purposes.

Participant Services Info

Please use the contact information listed below for any questions or concerns regarding services listed in the OE guide:

Phone Number: 1-866-451-3399

Website: customerservice@wexhealth.com

Flexible Spending Accounts (FSA)

Flexible Spending Accounts provide a great way to save money on your health and dependent care expenses.

	HEALTHCARE FSA	DEPENDENT CARE FSA
Eligible Expenses	Eligible medical, dental and vision expenses.	Child/elder care for eligible tax dependents that allow you and/or your spouse or domestic partner to work (medical, dental and vision expenses are not eligible for reimbursement with this account).
How It's Funded	▪ Paycheck contributions up to $3,400* per year. ▪ Your annual election amount is made during your enrollment period. You cannot change it unless you have a Qualifying Life Event during the year (such as getting married or having a baby). ▪ Your entire annual contribution is available to you at the beginning of the plan year.	▪ Paycheck contributions up to $7,500 per year per household (or to the maximum indexed amount announced by the IRS for the plan year, if different) to use for qualified dependent care or elder care expenses. ▪ Your election is made during your enrollment period. You cannot change it unless you have a Qualifying Life Event during the year (such as having a baby or a change in dependent care expenses). ▪ Your funds are only available to you after they have been deposited into your account each pay period.
Unused Funds	Up to $680** of unused money can be carried over to the next plan year, as long as you re-enroll in the healthcare FSA. Amounts above $680 will be forfeited.	You should estimate your expenses carefully before enrolling because unused funds in your account do not carry over at the end of the plan year and are forfeited.
How to Access	You will receive a benefits debit card that you can use to pay for eligible expenses. Or, you can submit claims for reimbursement of eligible expenses.	You will receive a benefits debit card that you can use to pay for eligible expenses. Or, you can submit claims for reimbursement of eligible expenses.

** Projected to increase to $3,500 for 2027; IRS approval pending.*
*** Projected to increase to $700 for 2027; IRS approval pending.*





Supplemental Medical

Unum

Supplemental Medical plans provide cash payments to help offset the cost of a covered medical event. These plans pay in addition to existing medical insurance benefits. **Benefits and covered conditions vary by state. Review plan documents to verify covered benefits.**

Hospital Indemnity

A hospital stay can cause serious financial setbacks due to medical costs or loss of income. Hospital Indemnity insurance provides benefits to help pay hospital and other bills related to a covered illness or injury.

- Collect a lump-sum benefit each day you are in the hospital*
- No coinsurance, copays, waiting periods or deductibles
- Benefits are paid directly to you, in addition to other insurance you may have
- Benefits are provided for hospital admission and daily hospital confinement**

**Limits apply.*
***Not a guarantee of coverage. Benefits may vary by state. Review plan documents to verify covered benefits.*

Benefit Example

Hospital Indemnity coverage is selected

You experience illness symptoms and visit a physician

You are admitted to the hospital

You spend several days in the hospital before release

Submit a claim and receive benefits for each day you are in the hospital

Critical Illness

Critical illnesses, such as heart attack, stroke, cancer or organ failure, are usually unexpected and may not be preventable. Recovering from a serious illness often brings significant expenses other than medical costs, which can amount to thousands of dollars.

- Coverage is guaranteed issue, which means you can qualify for coverage without having to answer any health questions
- Pays upon diagnosis of a covered condition
- Pays a lump-sum cash benefit directly to you to help cover out-of-pocket expenses associated with a covered critical illness
- Pays in addition to existing medical insurance benefits
- Examples of covered conditions include: cancer, heart attacks, stroke, major organ transplant, end stage renal failure*
- Some programs offer additional wellness incentives*

**Benefits and covered conditions vary by state. Review plan documents to verify covered benefits.*

Benefit Example

Critical Illness coverage is selected

You experience symptoms of a critical illness

You are treated by a physician

You are diagnosed with a covered critical illness

Submit a claim and receive a lump-sum benefit from your plan to help cover your expenses

Accident Insurance

An accident can require a variety of treatments, testing, therapies and other care to assist in recovery. Even the best medical plans may leave you with extra costs to pay out of your own pocket. Everyday expenses like your mortgage, car payment or childcare may be harder to cover due to lost or reduced income.

Accident insurance can help you bounce back by providing cash benefits if you experience a covered accident. These benefits help with expenses and protect your savings, letting you focus more on recovering.

- Receive cash benefits to help cover out-of-pocket expenses associated with a covered accident
- Pays in addition to existing medical insurance
- Pays benefits for each covered occurrence
- Examples of covered services include: emergency room, hospitalization, doctor's visits, physical therapy*
- Additional benefits available for certain injuries, such as dislocation, fractures, burns and lacerations*

**Not a guarantee of coverage. Benefits may vary by state. Review plan documents to verify covered benefits.*

Benefit Example

Accident insurance coverage is selected

You are injured in a covered accident

You visit a physician

You are treated for your injuries

Submit a claim and receive cash benefits from your plan to help cover expenses

Dental Insurance

Regular dental checkups and good oral hygiene are an essential part of your general health and well-being.

Key Words to Know:

The service examples below are not guarantees of coverage; please refer to plan documents to confirm covered services.

Annual Maximum Benefit: Maximum total amount the plan will pay during the plan year

Basic Services: Restorations, some oral surgery, endodontics and periodontics

Deductible: The amount you pay before the plan begins to pay

Major Services: Crowns, dentures, implants and some oral surgery

Orthodontia: Straightening or moving misaligned teeth and/or jaws with braces and/or surgery

Preventive Services: Designed to prevent or diagnose dental conditions, including oral evaluations, routine cleanings, X-rays, fluoride treatments and sealants

Review Your Dental Plan Options

Delta Dental

DELTA DENTAL PPO NETWORK

Dental Plan Summary

The following benefits are included in your plan options. Unless otherwise noted, benefits are per insured person and after deductible.

	ENHANCED WITH ORTHODONTIA	STANDARD
ANNUAL DEDUCTIBLE		
Individual	$50	$50
Family	$150	$150
BENEFIT MAXIMUM		
Annual Maximum	$2,000	$1,500
DENTAL BENEFIT COVERAGE		
Preventive Services	Plan pays 100%*	Plan pays 100%*
Basic Services	Plan pays 80%	Plan pays 80%
Major Services	Plan pays 50%	Plan pays 50%
ORTHODONTIA		
Benefit Coverage	Plan pays 50%	Not Covered
Lifetime Maximum	$2,500	Not Covered
Eligibility	Eligible children to age 19 and adults	Not Covered

**Deductible does not apply.*
In-network and out-of-network benefit provisions are the same, but may be applied differently for out-of-network services. Please refer to plan documents for additional details.



Vision Insurance

Regular eye exams can help keep your eyes healthy, while monitoring, preventing and treating easily correctable vision problems, which can cause permanent vision impairment.

Key Words to Know:

Copay: An amount you pay for a covered service each time you use that service

Retail Allowance: Maximum allowance paid toward the cost of vision materials; you are required to pay any amounts in excess of the retail allowance

Review Your Vision Plan Options

VSP Vision Care

Choice Network

Vision Plan Summary

The following in-network benefits are included in your plan options. Unless otherwise noted, benefits are per insured person.

	VSP BASE PLAN	VSP BUY-UP PLAN	
	COPAY		FREQUENCY
Exam	$25	$25	Once every calendar year
Lenses	$10	$10	Once every calendar year
Contact Lens Fitting	Up to $60 / 10% of Retail	Up to $60 / 10% of Retail	Once every calendar year
	RETAIL ALLOWANCE		FREQUENCY
Frames	Up to $180**	Up to $180**	Once every calendar year
Contact Lenses*	Up to $180	Up to $180	Once every calendar year
OPTIONAL UPGRADES			
	N/A	Members can choose one: An additional $50 frame allowance, or fully covered light-reactive lenses, or fully covered anti-glare coating, or an additional $50 contact lens allowance	Once every calendar year

**Conventional contact lens coverage provided in lieu of frames and lenses.*
***20% off any amount over the retail allowance.*
Please refer to plan documents for out-of-network benefits and additional details.

Life and AD&D Insurance

Life and Accidental Death and Dismemberment (AD&D) insurance can provide important financial protection for your family.

Key Words to Know:

Accidental Death & Dismemberment Insurance: Pays a benefit upon the accidental death of an insured person; also provides benefits for certain covered accidental dismemberments

Beneficiary: Person or legal entity designated as the recipient of benefits from Life or AD&D insurance

Evidence of Insurability (EOI): Statement of health proving a person's eligibility for certain amounts of coverage

Guaranteed Issue: An amount of insurance that does not require evidence of insurability

Life Insurance: Pays a benefit upon the death of an insured person

Employer-Paid Term Life and AD&D Insurance

New York Life

Health Plan of San Joaquin provides you with a base level of employee Term Life and AD&D insurance at no cost to you. This coverage provides a benefit of two times your salary, rounded to the next higher $1,000, up to $250,000.

Optional Employee-Paid Term Life and AD&D Insurance

New York Life

PLAN	DETAILS
Employee Term Life	Elect in $50,000 increments, up to $500,000. Your guaranteed issue of $150,000 is available only during your initial enrollment period. **You must purchase this coverage if you wish to purchase Spouse, Domestic Partner, and/or Child Term Life.**
Employee AD&D**	Elect in $50,000 increments, up to $500,000.*
Spouse/Domestic Partner Term Life	Elect in $25,000 increments, up to $50,000, not to exceed 100% of employee coverage.
Child Term Life	Coverage is $500 from birth to 14 days, $1,000 for ages 15 days to 6 months, $10,000 for ages 6 months to 26 years. Coverage ends at age 26.

**Benefit reduction due to age may apply. Review plan documents for additional details.*
***You may elect Optional AD&D coverage for yourself, or for yourself and your family. If Family AD&D is elected, dependent coverage is a portion of employee coverage and all of your eligible dependents are covered under one rate. No EOI is required for Optional AD&D coverage.*

This coverage is tied to your employment and typically ends if you leave your employer. However, you may be offered the opportunity to retain coverage on your own with the same insurance carrier.

Evidence of Insurability (EOI):

Life insurance amounts over guaranteed issue coverage may require a statement of health and approval from the insurance carrier. After electing coverage, you will receive more information.

Don't Forget to Select a Beneficiary!

Choose a beneficiary to receive the policy's benefit payment in the event of the insured person's death. The employee is automatically listed as the beneficiary for dependent coverage.



Disability Insurance

If you become disabled and are unable to work, Disability insurance can replace a percentage of your lost income to help you continue to pay living expenses.

Key Words to Know:

Long Term Disability: When you are unable to work for an extended period of time due to a disabling illness or injury, Long Term Disability insurance can replace a percentage of your lost income (up to a maximum monthly benefit) for a period of time as defined by the policy.

Disability Benefits Summary

New York Life

Employer-Paid Disability

EMPLOYER-PAID LONG TERM DISABILITY	
Benefit Provided	66.7% of salary
Maximum Benefit Amount	$12,500 per month
Maximum Benefit Period (including waiting period)	Until you no longer meet the definition of disability or reach the maximum benefit duration as defined by the policy
Waiting Period	90 days

Your Long Term Disability benefits will be coordinated between HPSJ and the state of California.

As part of the benefits package offered by Health Plan of San Joaquin, you have access to a variety of additional programs that can help save you money and provide important assistance with everyday needs. For detailed benefits information, email **benefits@hpsj.com**.



Voluntary Benefits

Health Plan of San Joaquin provides access to a variety of additional programs that can help you save money. and access care.

Identity Theft and Cyber Protection

Allstate Identity Protection

This benefit offers you the most comprehensive solution to fight today's identity fraud issues and provide cyber protection. Benefits include:

- Identity and credit monitoring alerts to uncover fraud quickly
- An annual credit report and a score each month, making it easier to monitor your credit
- Social media monitoring to protect against cyberbullying and reputational damage within sites
- A digital wallet for securely storing documents and credit cards with a lost wallet replacement service
- Threshold monitoring to view and manage your financial transactions from all your accounts in one place
- Cyber protection including antivirus protection, password manager, VPN, firewall, and network security for up to 5 mobile and desktop devices

Legal Plan

MetLife® Legal

Finding an affordable attorney can be a challenge. This plan helps you find legal representation for you and your family for legal matters, including:

- Wills and Estate Planning
- Family Law (Name Change, Adoption)
- Consumer Protection (Auto Repair, Consumer Fraud)
- Juvenile Court Matters (Includes Criminal Matters)
- Debt-Related Matters (Bankruptcy, Tax Audits)
- Elder Law Matters (Consultations, Document Review)
- Home and Real Estate Matters (Purchase or Sale of a Home, Security Deposits)

The plan is easy to use — no copayments, deductibles or waiting periods!

Company Paid Benefits

Available year-round!

Online Discount Mall PerkSpot

PerkSpot is a one-stop shop for exclusive discounts at many of your favorite national and local merchants. It's completely free and optimized for use on any device: desktops, tablets and phones. Take advantage of online offers and discover discounts in your neighborhood with PerkSpot's streamlined Local Map. Filter your map results by categories like restaurants, health and fitness, retail and more.

Opt in to PerkSpot's weekly email to receive a curated selection of discounts. Each week's email features both new and popular deals, as well as seasonal, holiday and group offers.

Aduro Wellness Program

Aduro is a comprehensive wellness platform designed to support your health and well-being through personalized coaching, interactive challenges and valuable resources. You can easily access Aduro to set wellness goals, track your progress and engage in activities that promote a healthier lifestyle. Take advantage of Aduro's tools to empower yourself and make the most of your wellness benefits this year.



Employee Assistance Program (EAP)

This program offers confidential counseling, legal and financial counseling, work-life assistance, well-being coaching, family care services, and crisis intervention services to covered employees and their household family members. Health Plan of San Joaquin offers 3 in-person or virtual counseling sessions.

Core Advocacy

Health Advocate

One phone call connects you to a Personal Health Advocate who can help you resolve complex issues about healthcare. Your advocate can also help with:

- Locate qualified doctors, hospitals and specialists nationwide, including options for second opinions and hard-to-reach providers
- Clarify complex conditions, research available treatment options, and answer questions about test results and medications
- Resolve insurance claims, uncover billing errors, negotiate payment arrangements and find options for non-covered services
- Assist with special needs by finding caregiver support, in-home care, rehabilitation resources, and expediting coverage for medical procedures and equipment
- Address elder care issues: clarify Medicare; locate adult day care, assisted living and long-term care; and research transportation to appointments



Member Resources

Aetna Member's Virtual Health

24-Hour Nurse Line*

A simple call can make all the difference

Have questions about upcoming medical visits and choices? You can talk to a registered nurse for information about tests, procedures and treatment options, 24 hours a day, 7 days a week. And the call is free. To find the phone number, just visit www.aetna.com and log in to your member website.

*While only your doctor can diagnose, prescribe or give medical advice, our 24-Hour Nurse Line nurses can provide information on a variety of health topics. Contact your doctor first with any questions about your healthcare needs.

Teledoc Health®

Teladoc doctors can diagnose, treat and prescribe medication when necessary for a wide range of non-urgent medical issues, including dermatology and mental health. Connect with a doctor at your convenience by computer or mobile app today. Visit teladoc.com/aetna or the Teladoc app for more information.

TELADOC SERVICES*	DETAILS
General medicine visit ▪ Respiratory infection ▪ Allergies ▪ Cold and flu ▪ Bronchitis ▪ Pink eye ▪ Sinus problems	Talk to a licensed doctor for non-emergency conditions 24/7 like flu, sinus infections, sore throats and more.
Mental healthcare visit ▪ Anxiety disorder ▪ Substance abuse	Talk to a therapist seven days a week (7 a.m. to 9 p.m. local time).
Dermatology visit ▪ Skin problems like eczema, acne, rash and more ▪ General dermatology	Upload images of a skin issue online and get a custom treatment plan in two days.

**Limitations may apply.*

GuidanceResources

New York Life

New York Life recognizes that life can present many challenges, from financial uncertainties to work-life stressors. To support you during these times, New York Life offers a range of guidance resources designed to provide clarity and assistance, helping clients navigate their unique situations with confidence and peace of mind. See **Page 20** for contact information.

PROGRAM	DESCRIPTION
Financial, Legal and Estate Support	Our Financial, Legal and Estate Support Program provides consultative experts to meet the needs of your business and employees.
Survivor Assurance	This program provides support for beneficiaries when they need it the most with a NYL GBS Survivor Assurance Account; Financial, Legal and Estate Support; and Employee Assistance and Wellness Support.
Secure Travel	Provides pre-trip planning, assistance while traveling, and unlimited medical evacuation and repatriation.

Kaiser Members Virtual Health

RESOURCES	
Online Health Programs	Free online programs to help manage conditions, weight loss, quit smoking and others.
ChooseHealthy Program	▪ Alternative care resources for staying active and healthy ▪ Including preferred rates for acupuncture, chiropractic care, fitness center access and massage therapy.
Wellness Coach	Free 1-on-1 guidance and support from a dedicated coach to help set and achieve your goals.
Calm App	Designed for meditation and sleep, Calm helps lower stress, reduce anxiety and more.



Employee Contribution Rates

The per-pay-period contributions may differ slightly from what is shown on the enrollment site due to rounding. View additional rates for plans not listed below at www.workforcenow.adp.com.

Full-Time Medical Plan Rates (Per 26 Paychecks)

	AETNA OAMC $2,000	AETNA HMO $750	KAISER HMO	KAISER DHMO
Employee Only	$69.73	$69.73	$75.10	$54.49
Employee + Spouse	$288.64	$337.49	$553.62	$283.36
Employee + Child(ren)	$202.68	$248.24	$427.13	$207.07
Employee + Family	$482.01	$538.31	$838.25	$455.01

Full-Time Dental Plan Rates (Per 26 Paychecks)

	STANDARD	ENHANCED WITH ORTHODONTIA
Employee Only	$0.00	$4.76
Employee + Spouse	$6.71	$16.65
Employee + Child(ren)	$5.66	$14.79
Employee + Family	$13.36	$28.43

Full-Time Vision Plan Rates (Per 26 Paychecks)

	BASE PLAN	BUY-UP PLAN
Employee Only	$0.00	$0.48
Employee + Spouse	$0.79	$1.74
Employee + Child(ren)	$0.90	$1.92
Employee + Family	$1.91	$3.53

Full-Time Hospital Indemnity and Accident Insurance Rates (Per 26 Paychecks)

	HOSPITAL INDEMNITY	ACCIDENT INSURANCE
Employee Only	$12.35	$4.21
Employee + Spouse	$20.52	$7.48
Employee + Child(ren)	$16.98	$9.88
Employee + Family	$25.15	$13.15

Full-Time Critical Illness Rates (Per 26 Paychecks)

AGE	CRITICAL ILLNESS					
	EMPLOYEE + CHILD(REN)			SPOUSE		
	$10,000	$20,000	$30,000	$5,000	$10,000	$30,000
< 25	$1.85	$3.69	$5.54	$1.85	$3.69	$5.54
25–29	$2.26	$4.52	$6.78	$2.26	$4.52	$6.78
30–34	$2.54	$5.08	$7.62	$2.54	$5.08	$7.62
35–39	$3.09	$6.18	$9.28	$3.09	$6.18	$9.28
40–44	$3.78	$7.57	$11.35	$3.78	$7.57	$11.35
45–49	$4.71	$9.42	$14.12	$4.71	$9.42	$14.12
50–54	$5.91	$11.82	$17.72	$5.91	$11.82	$17.72
55–59	$7.80	$15.60	$23.40	$7.80	$15.60	$23.40
60–64	$11.03	$22.06	$33.09	$11.03	$22.06	$33.09
65–69	$14.77	$29.54	$44.31	$14.77	$29.54	$44.31
70–74	$21.18	$42.37	$63.55	$21.18	$42.37	$63.55
75–79	$29.12	$58.25	$87.37	$29.12	$58.25	$87.37
80–84	$38.31	$76.62	$114.92	$38.31	$76.62	$114.92
85+	$52.80	$105.60	$158.40	$52.80	$105.60	$158.40

Voluntary Life and AD&D Rates (Per 26 Paychecks)

AGE	VOLUNTARY LIFE AND AD&D	
	EMPLOYEE VOLUNTARY LIFE	SPOUSE VOLUNTARY LIFE
	PER $1,000 COVERED	PER $1,000 COVERED
<25	$0.023	$0.023
25–29	$0.028	$0.028
30–34	$0.037	$0.037
35–39	$0.042	$0.042
40–44	$0.046	$0.046
45–49	$0.074	$0.074
50–54	$0.138	$0.138
55–59	$0.231	$0.231
60–64	$0.342	$0.342
65–69	$0.600	$0.600
70–74	$1.246	$1.246
75.79	$1.892	$1.892
80+	$1.892	$1.892

CHILD VOLUNTARY LIFE
PER $1,000 COVERED
$0.106

VOLUNTARY AD&D	
PER $1,000 COVERED	
Employee Only	$0.009
Employee + Family	$0.014

MetLife Group Legal Rates (Per 26 Paychecks)

	METLIFE GROUP LEGAL
Employee Only	$11.08

Allstate ID Theft Rates (Per 26 Paychecks)

	ALLSTATE ID THEFT
Employee Only	$4.59
Employee + Family	$8.75

Carrier Contact Information

BENEFIT	INSURER/ ADMINISTRATOR	PHONE NUMBER	WEBSITE/EMAIL
Medical and Prescription	Aetna, Policy #237650	HMO: **1-800-445-5299** OAMC: **1-877-204-9186**	www.aetna.com www.aetnaresource.com/lg/HPSJ-2027-Benefits-Guide
Medical and Prescription	Kaiser Permanente Policy #607514	**1-800-464-4000**	www.kp.org
Flexible Spending Accounts	WEX Group ID #47164	**1-866-451-3399**	wexinc.com/contact/health
Supplemental Medical (Accident, Critical Illness, Hospital Indemnity)	Unum Policy #23225	**1-800-635-5597** 5 a.m.–5 p.m. PT Monday–Friday	www.unum.com/employees
Dental	Delta Dental Policy #21117	**1-888-335-8227**	www.deltadentalins.com
Vision	VSP Policy #40157057	**1-800-877-7195**	vsp.com
Term Life / AD&D	New York Life Life #FLX967616 AD&D #OK969122	**1-866-799-2725**	www.newyorklife.com/group-benefit-solutions/employees
Disability	New York Life LTD #LK965209	**1-866-799-2725**	www.newyorklife.com/group-benefit-solutions/employees
Legal	MetLife Legal Policy #5940618	**1-800-821-6400**	www.legalplans.com
Identity Theft	Allstate Identity Protection Policy #1529	**1-800-789-2720**	www.myaip.com
Online Discount Mall	PerkSpot	**1-866-606-6057**	https://mercerperks.perkspot.com/
Benefits Enrollment Website	ADP	N/A	www.workforcenow.adp.com
GuidanceResources: ▪ **Employee Assistance and Wellness Support** ▪ **Financial, Legal and Estate Support**	New York Life	**1-800-344-9752**	guidanceresources.com Web ID: NYLGBS
GuidanceResources: ▪ **Survivor Assurance** ▪ **Survivor Support Specialist**	New York Life	Survivor Assurance: **1-800-570-3778** Survivor Support Specialist: **1-888-842-4462 ext. 1013382**	N/A
GuidanceResources: • **Secure Travel**	New York Life Policy #OK-969122 Group #57	From the United States and Canada, call **1-888-226-4567** From other locations, call collect **1-202-331-7635** Fax: **1-202-331-1528**	Email: ops@us.generaliglobalassistance.com
Wellness	Aduro		

Required Notices



HEALTH PLAN OF SAN JOAQUIN RESERVES THE RIGHT TO CHANGE, AMEND OR TERMINATE ANY BENEFITS PLAN AT ANY TIME FOR ANY REASON. PARTICIPATION IN A BENEFITS PLAN IS NOT A PROMISE OR GUARANTEE OF FUTURE EMPLOYMENT. RECEIPT OF BENEFITS DOCUMENTS DOES NOT CONSTITUTE ELIGIBILITY.

The Benefits Decision Guide, combined with these legal notices, provides an overview of the benefits available to eligible employees and their dependents. In all cases, the official plan documents govern and this Benefits Decision Guide is not, and should not be relied upon as a governing document. In the event of a discrepancy between the information presented in the Benefits Decision Guide and official plan documents, the official plan documents will govern.

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) or Summary of Material Reductions (SMR), as applicable, to the Health Plan of San Joaquin summary plan description (SPD). It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

SUMMARY OF BENEFITS COVERAGE

A Summary of Benefits Coverage (SBC) for each of the employer-sponsored medical plans is available at Health Plan of San Joaquin's Internal Share point.

TAXATION OF BENEFITS

The taxation of certain benefits may vary at the local, state and federal level. You should consult your tax advisor if you have any questions about the proper treatment of any benefits.

IMPORTANT NOTICE FROM HEALTH PLAN OF SAN JOAQUIN ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Health Plan of San Joaquin medical plans is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2027. This is known as "creditable coverage."

Why this is important: If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2027 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty — as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Health Plan of San Joaquin and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

NOTICE OF CREDITABLE COVERAGE

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Health Plan of San Joaquin prescription drug plans listed below, you'll be interested to know that the prescription drug coverage under the plan is, on average, at least as good as standard Medicare prescription drug coverage for 2027. This is called creditable coverage.

Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

- Kaiser HMO
- Kaiser DHMO
- Aetna HMO $750
- Aetna OAMC $2,000

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage.

In this case, the Health Plan of San Joaquin plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Health Plan of San Joaquin coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the Health Plan of San Joaquin plan, assuming you remain eligible.

You should know that if you waive or leave coverage with Health Plan of San Joaquin and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug

plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if this Health Plan of San Joaquin coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number) or visit the program online at https://www.shiptacenter.org/.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Human Resources Department, Health Plan of San Joaquin

7751 South Manthey Road, French Camp, CA 95231-9802
(209) 942-6300
benefits@hpsj.com

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) SPECIAL ENROLLMENT NOTICE

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR HEALTH PLAN COVERAGE

If you have declined enrollment in Health Plan of San Joaquin's health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under these plans without waiting for the next Open Enrollment period, provided you request enrollment within 30 days after your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Health Plan of San Joaquin will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30– from the date of the Medicaid/CHIP eligibility change to request enrollment in the Health Plan of San Joaquin group health plan. Note that this 60-day extension does not apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your medical carrier at the phone number listed on the back of your ID card.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your medical carrier at the phone number listed on the back of your ID card.

MICHELLE'S LAW NOTICE

EXTENDED DEPENDENT MEDICAL COVERAGE DURING STUDENT MEDICAL LEAVES

The Employer plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from a post-secondary educational institution (including a college or university). Coverage may continue for up to a year, unless the child's eligibility would end earlier for another reason.

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

If the coverage provided by the plan is changed during this one-year period, the plan will provide the changed coverage for the remainder of the leave of absence.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION:

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Health Plan of San Joaquin may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are your providers in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact benefits@hpsj.com

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility –

ALABAMA – MEDICAID

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

ALASKA – MEDICAID

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

ARKANSAS – MEDICAID

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

CALIFORNIA – MEDICAID

Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp or Health Insurance Premium Payment Program/Cost Avoidance | DHCS
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – MEDICAID

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

GEORGIA – MEDICAID

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

ILLINOIS - MEDICAID

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

INDIANA – MEDICAID

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – MEDICAID

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

KENTUCKY – MEDICAID

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

LOUISIANA – MEDICAID

Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP)
Website: https://www.ldh.la.gov/lahipp
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

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 AND CHIP

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

MINNESOTA – MEDICAID

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

MISSOURI – MEDICAID

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

MONTANA – MEDICAID

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

NEBRASKA – MEDICAID

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

NEVADA – MEDICAID

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

NEW HAMPSHIRE – MEDICAID

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

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website: https://www.nj.gov/humanservices/dmahs/clients/medicaid/ or NJ FamilyCare/Medicaid | Division of Medical Assistance and Health Services (Note to ICI - Text NJ FamilyCare/Medicaid | Division of Medical Assistance and Health Services
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – MEDICAID

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

NORTH CAROLINA – MEDICAID

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – MEDICAID

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825 or 866-614-6005

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 AND CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – MEDICAID AND CHIP

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

SOUTH CAROLINA – MEDICAID

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

SOUTH DAKOTA - MEDICAID

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

TEXAS – MEDICAID

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – MEDICAID AND CHIP

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

VERMONT– MEDICAID

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – MEDICAID AND CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – MEDICAID

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

WEST VIRGINIA – MEDICAID AND CHIP

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

WISCONSIN – MEDICAID AND CHIP

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

WYOMING – MEDICAID

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

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

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 5/31/2029)

PHYSICIAN DESIGNATION NOTICE

The Aetna HMO $750, Kaiser Permanente HMO, and Kaiser Permanente DHMO plans generally require 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 Aetna and Kaiser designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Aetna at 1-800-445-5299 or Kaiser Permanente at 1-800-464-4000.

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

You do not need prior authorization from Aetna or Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare 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 healthcare professionals who specialize in obstetrics or gynecology, contact Aetna at 1-800-445-5299 or Kaiser Permanente at 1-800-464-4000.

HEALTH PLAN OF SAN JOAQUIN HIPAA PRIVACY NOTICE

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Health Plan of San Joaquin health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium or as an oral communication. This notice describes the privacy practices of these plans:

Healthcare Flexible Spending Account.

The plans covered by this notice may share health information with each other to carry out treatment, payment or healthcare operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

THE PLAN'S DUTIES WITH RESPECT TO HEALTH INFORMATION ABOUT YOU

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Health Plan of San Joaquin as an employer — that's the way the HIPAA rules work. Different policies may apply to other Health Plan of San Joaquin programs or to data unrelated to the Plan.

HOW THE PLAN MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of healthcare treatment, payment activities and healthcare operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing healthcare by one or more healthcare providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for healthcare. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Healthcare operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service and internal grievance resolution. Healthcare operations also include evaluating vendors; engaging in credentialing, training and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses Personal Health Information (PHI) for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

HOW THE PLAN MAY SHARE YOUR HEALTH INFORMATION WITH HEALTH PLAN OF SAN JOAQUIN

The Plan, or its health insurer or Health Maintenance Organization (HMO), may disclose your health information without your written authorization to Health Plan of San Joaquin for plan administration purposes. Health Plan of San Joaquin may need your health information to administer benefits under the Plan. Health Plan of San Joaquin agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Members of the benefits, payroll and/or finance staff are the only Health Plan of San Joaquin employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Health Plan of San Joaquin, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Health Plan of San Joaquin, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Health Plan of San Joaquin information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Health Plan of San Joaquin cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Health Plan of San Joaquin from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative. The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

- **Workers' compensation:** Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
- **Necessary to prevent serious threat to health or safety:** Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
- **Public health activities:** Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
- **Victims of abuse, neglect, or domestic violence:** Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
- **Judicial and administrative proceedings:** Disclosures in response to a court or administrative order, subpoena, discovery request or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
- **Law enforcement purposes:** Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
- **Decedents:** Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
- **Organ, eye or tissue donation:** Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
- **Research purposes:** Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
- **Health oversight activities:** Disclosures to health agencies for activities authorized by law (audits, inspections, investigations or licensing actions) for oversight of the healthcare system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
- **Specialized government functions:** Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
- **HHS investigations:** Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

HOW THE PLAN WILL TREAT CERTAIN SUD TREATMENT INFORMATION

The Plan is not a federally assisted substance use disorder diagnosis, treatment or referral program that is covered by 42 CFR Part 2 (a "Part 2 Program") and does not create and does not typically maintain any records that are subject to 42 CFR Part 2. If the Plan does receive any Part 2 Program records pursuant to your written consent for claim administration and payment, the records will only be used and disclosed in accordance with HIPAA and your consent. In no event will the Plan use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings against you, unless authorized by your written consent or a court order accompanied by a subpoena or other legal requirement compelling disclosure after you received notice and an opportunity to respond.

YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the Contact section at the end of this notice for information on how to submit requests.

RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION AND THE PLAN'S RIGHT TO REFUSE

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or healthcare operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your healthcare provider) or its business associate must comply with your request that health information regarding a specific healthcare item or service not be disclosed to the Plan for purposes of payment or healthcare operations if you have paid out of pocket and in full for the item or service.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF YOUR HEALTH INFORMATION

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a healthcare provider; enrollment, payment, claims adjudication and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings.

The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested.
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint.
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

RIGHT TO AMEND YOUR HEALTH INFORMATION THAT IS INACCURATE OR INCOMPLETE

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons.

For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested.
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint.
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION

You have the right to a list of certain disclosures of your health in-formation the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the Other Allowable Uses or Disclosures of your Health Information section earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment or healthcare operations.
- To you about your own health information.
- Incidental to other permitted or required disclosures.
- Where authorization was provided.
- To family members or friends involved in your care (where disclosure is permitted without authorization).
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM THE PLAN UPON REQUEST

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

CHANGES TO THE INFORMATION IN THIS NOTICE

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on 2/16/2026. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice.

COMPLAINTS

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact benefits@hpsj.com.

CONTACT

For more information on the Plan's privacy policies or your rights under HIPAA, contact benefits@hpsj.com.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain minimum value standards. The savings on your premium that you're eligible for depends on your household income. You may be eligible for a tax credit that lowers your cost.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than **10.22% for 2027**[1] of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[2]

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 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. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact benefits@hpsj.com or call 209-942-3600.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-26-26.pdf for 2027.

[2] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

What About Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact benefits@hpsj.com

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Health Plan of San Joaquin	4. Employer Identification Number (EIN) 68-0355833	
5. Employer address 7751 South Manthey Road	6. Employer phone number 209-942-3600	
7. City French Camp	8. State California	9. Zip code 95231
10. Who can we contact about employee health coverage at this job? Human Resources Department		
11. Phone number (if different from above)	12. Email address benefits@hpsj.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Employees who work at least 20 hours a week

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouses, dependents/children, domestic partners,registered domestic partners

☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

NO SURPRISES ACT NOTICE

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

What is "balance billing" (sometimes called "surprise billing")?

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

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

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

You're protected from balance billing for:
Emergency services

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

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

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

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

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

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:

– Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

– Cover emergency services by out-of-network providers.

– Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.

– Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact U.S. Department of Health and Human Services. The federal phone number for information and complaints is: 1-800-985-3059. Visit **No Surprises Act | CMS** for more information about your rights under federal law.

Notes

Notes



This guide highlights the main features of the Health Plan of San Joaquin/Mountain Valley Health Plan Employee Benefits Program. It does not include all plan rules, details, limitations and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this guide and the legal plan documents, the plan documents are the final authority. Health Plan of San Joaquin/Mountain Valley Health Plan reserves the right to change or discontinue its employee benefits plans at any time.