Tulare County Probation Association

2026

Benefit Summary

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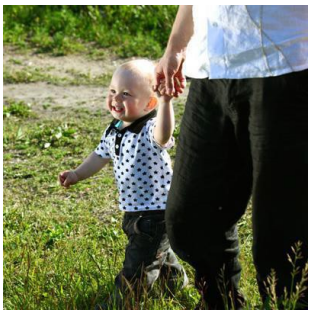
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 22-23 where Notice of Creditable Coverage begin for more details.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.



Who is Eligible?

If you are a Tulare County Probation Association full-time employee you, your spouse, and your dependent children to age 26 are eligible to enroll in the Medical, Dental & Vision benefits described in this guide. TCPA retirees under the age of 65 and their eligible dependents under the age of 65 are also eligible for benefits under the TCPA Early Retiree Plan.

How to Enroll

The first step is to review your benefit options and determine which plan best suits your needs. Complete the required TCPA enrollment and/or waiver forms. Once you have made your elections, you will not be able to change them until the next open enrollment period, unless you have a qualified change in status.

When to Enroll

The benefits you elect will be effective through December 31, 2026. New hires will be eligible the first of the month following 2 months from their date of hire. Tulare County employees transferring to TCPA Bargaining Unit 12 are effective the first of the month following the date benefits end under your prior Tulare County plan. ***Benefit premiums are deducted one month prior to the employee benefit effective date. All benefit forms MUST be received no later than 3 weeks following date of employment o avoid retro-pay deductions.***

When to Make Changes

Unless you have a qualified change in status, you cannot make changes to the benefits you elect until the next open enrollment period. Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status. You have **30 days** from a change in family status to make changes.

What do you need to do during your ENROLLMENT period?

1. Review the benefit summaries and premium deduction sections enclosed in this document. Benefits are bundled so if you wish to enroll in one of the offered health care plans, you will be enrolled in the other two as well. (Example: If you choose to enroll you and your children in medical, you and your children will also be enrolled in dental and vision.)

2. All highlighted areas on the enrollment forms must be completed for yourself and any dependents you are enrolling in the TCPA health plan.

3. If you are already enrolled in a health insurance plan and do not wish to join the Tulare County Probations health insurance plan, you must complete the Tulare County Opt Out form at the end of this booklet.

Kaiser is only available to employees living in Fresno, Kern and zip code 93230 in Kings County.

If you have any questions regarding your TCPA enrollment, please call your Gallagher Benefit Advocate Team

Benefit Advocate Center Hours of Operation

Monday - Friday: 8am - 6pm in local time zone
Ph: 425.201.9143 / Email: bac.tcpacso@ajg.com

Gallagher is ready to help you get the most from your benefits program by providing support from an advocate at no cost to you.

NOTE: After the Open Enrollment Period, you cannot make changes to your coverage during the year unless you experience a change in family status, such as:

- **Loss or gain of coverage through your spouse**
- **Loss of eligibility of a covered dependent**
- **Death of your covered spouse or child**
- **Birth or adoption of a child**
- **Marriage, divorce or legal separation**
- **Switch from part-time employment to full-time employment**

You have 30 days from a change in family status to make changes to your current coverage.

Medical Benefits

Administered by Anthem

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through Tulare County Probation Association.

Tulare County Probation Association offers you a choice of two (2) PPO and one (1) HMO medical plans. With the PPO, you may select where you receive your medical services. If you use in-network providers, your costs will be less.

	Anthem Premier HMO 20/100%	Anthem Classic PPO 500/20/40/20		Anthem Classic PPO 1000/35/55/20	
	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Benefit Maximum	Unlimited	Unlimited		Unlimited	
Annual Deductible	$0 single / $0 family	$500 single / $1,500 family	$1,500 single / $4,500 family	$1,000 single / $3,000 family	$3,000 single / $9,000 family
Annual Out-of-Pocket Maximum	$1,500 single / $3,000 family	$3,500 single / $7,000 family	$10,500 single / $21,000 family	$5,000 single / $10,000 family	$15,000 single / $30,000 family
Coinsurance	0%	20%	40%	20%	40%
Doctor's Office					
Primary Care Office Visit	$20 copay per visit	$20 copay per visit	40% after deductible	$35 copay per visit	40% after deductible
Specialist Office Visit	$20 copay per visit	$40 copay per visit	40% after deductible	$55 copay per visit	40% after deductible
Preventive Care (screenings, immunizations)	0%	0%	40% after deductible	0%	40% after deductible
Prescription Drugs					
Retail—Tier 1a - Typically Lower Cost Generic (30-day supply)	$5 copay per prescription	$5 copay per prescription	50% up to $250 copay per prescription	$5 copay per prescription	50% up to $250 copay per prescription
Retail—Tier 1b - Typically Generic (30-day supply)	$15 copay per prescription	$20 copay per prescription	50% up to $250 copay per prescription	$20 copay per prescription	50% up to $250 copay per prescription
Retail—Tier 2 – Typically Preferred Brand & Non-Preferred Generic (30-day supply)	$30 copay per prescription	$30 copay per prescription	50% up to $250 copay per prescription	$30 copay per prescription	50% up to $250 copay per prescription
Retail—Tier 3 - Typically Non-Preferred Brand and Generic (30-day supply)	$50 copay per prescription	$50 copay per prescription	50% up to $250 copay per prescription	$50 copay per prescription	50% up to $250 copay per prescription
Retail—Tier 4 - Typically Preferred Specialty (Brand and Generic) (30-day supply)	30% up to $250 copay per prescription	30% up to $250 copay per prescription	50% up to $250 copay per prescription	30% up to $250 copay per prescription	50% up to $250 copay per prescription
Mail Order—Tier 1a - Typically Lower Cost Generic (90-day supply)	$12.50 copay per prescription	$12.50 copay per prescription	Not Covered	$12.50 copay per prescription	Not Covered
Mail Order—Tier 1b - Typically Generic (90-day supply)	$37.50 copay per prescription	$50 copay per prescription	Not Covered	$50 copay per prescription	Not Covered
Mail Order—Tier 2 – Typically Preferred Brand & Non-Preferred Generic (90-day supply)	$90 copay per prescription	$90 copay per prescription	Not Covered	$90 copay per prescription	Not Covered
Mail Order—Tier 3 - Typically Non-Preferred Brand and Generic (90-day supply)	$150 copay per prescription	$150 copay per prescription	Not Covered	$150 copay per prescription	Not Covered
Mail Order—Tier 4 - Typically Preferred Specialty (Brand and Generic) (90-day supply)	30% up to $250 copay per prescription	30% up to $250 copay per prescription	Not Covered	30% up to $250 copay per prescription	Not Covered

Medical Benefits (Continued)

Administered by Anthem

	Anthem Premier HMO 20/100%	Anthem Classic PPO 500/20/40/20		Anthem Classic PPO 1000/35/55/20	
	In-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospital Services					
Emergency Room (Copay waived if admitted)	$100 copay per visit	$150 copay per visit then 20% after deductible	$150 copay per visit then 20% after deductible	$150 copay per visit then 20% after deductible	$150 copay per visit then 20% after deductible
Inpatient	0%	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Surgery	0%	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Ambulance Service	$100 copay per trip	20% after deductible		20% after deductible	
Mental Health Services					
Inpatient Services	0%	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Services	Office Visit: $20 copay per visit Other Outpatient: 0%	Office Visit: $20 copay per visit; Other Outpatient: 20% after deductible	40% after deductible	Office Visit: $35 copay per visit; Other Outpatient: 20% after deductible	40% after deductible
Substance Abuse Services					
Inpatient Services	0%	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Services	Office Visit: $20 copay per visit Other Outpatient: 0%	Office Visit: $20 copay per visit; Other Outpatient: 20% after deductible	40% after deductible	Office Visit: $35 copay per visit; Other Outpatient: 20% after deductible	40% after deductible
Other Services					
Maternity Services	$20 copay per visit	$20 copay per visit	40% after deductible	$35 copay per visit	40% after deductible
All other maternity hospital/ physician services	0%	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Muscle Manipulation Services	$20 copay per visit (20 visits)	$20 copay per visit (30 visits)	40% after deductible (30 visits)	$35 copay per visit (30 visits)	40% after deductible (30 visits)
Physical, Occupational and Speech Therapy Services	$20 copay per visit*	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Skilled Nursing 150-day calendar year maximum	0%	20% after deductible	40% after deductible	20% after deductible	40% after deductible

*physical and occupational therapies is limited to 40 visits and Therapy is limited to 20 visits

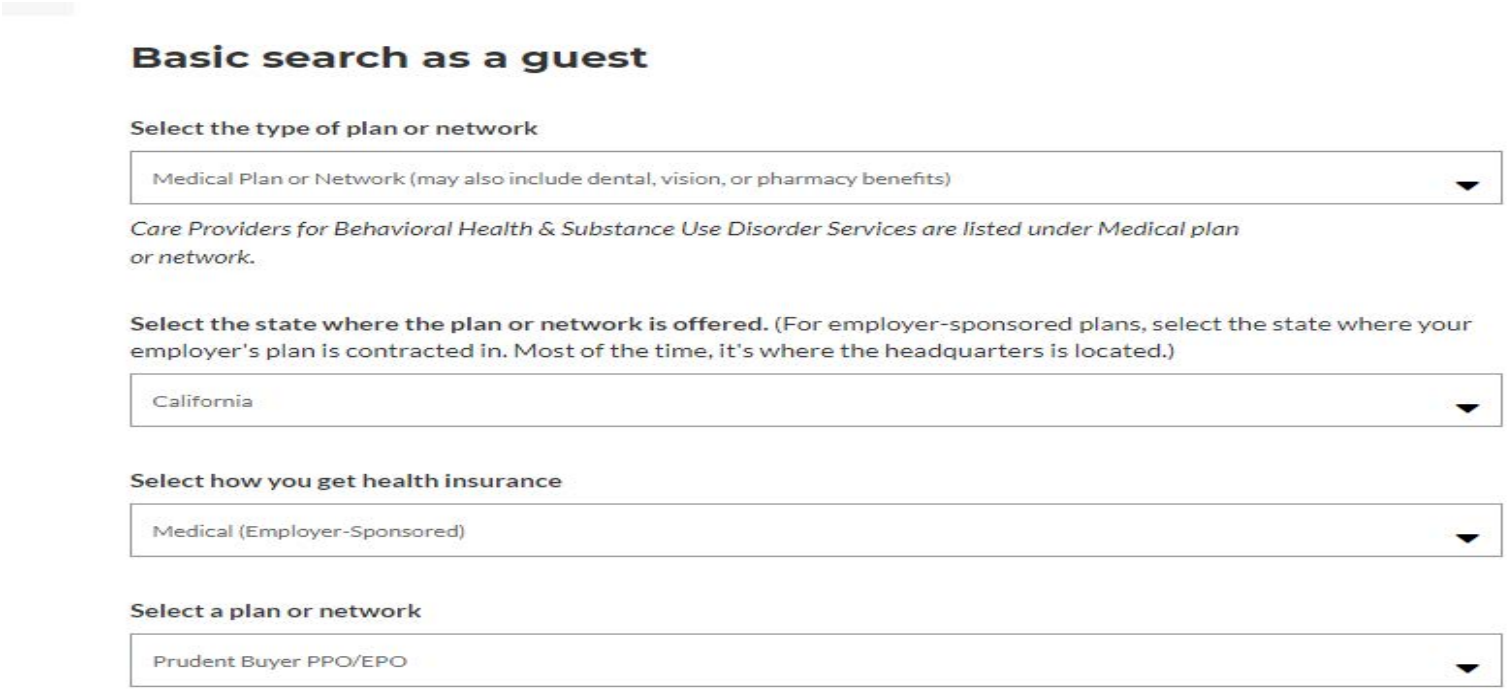
How to Choose a Primary Care Physician

If you choose to enroll in the Anthem HMO plan, you will be required to choose a Primary Care Physician (PCP) on your enrollment form. If you do not elect one, Anthem will elect one for you. You are not required to elect a PCP for the PPO plans.

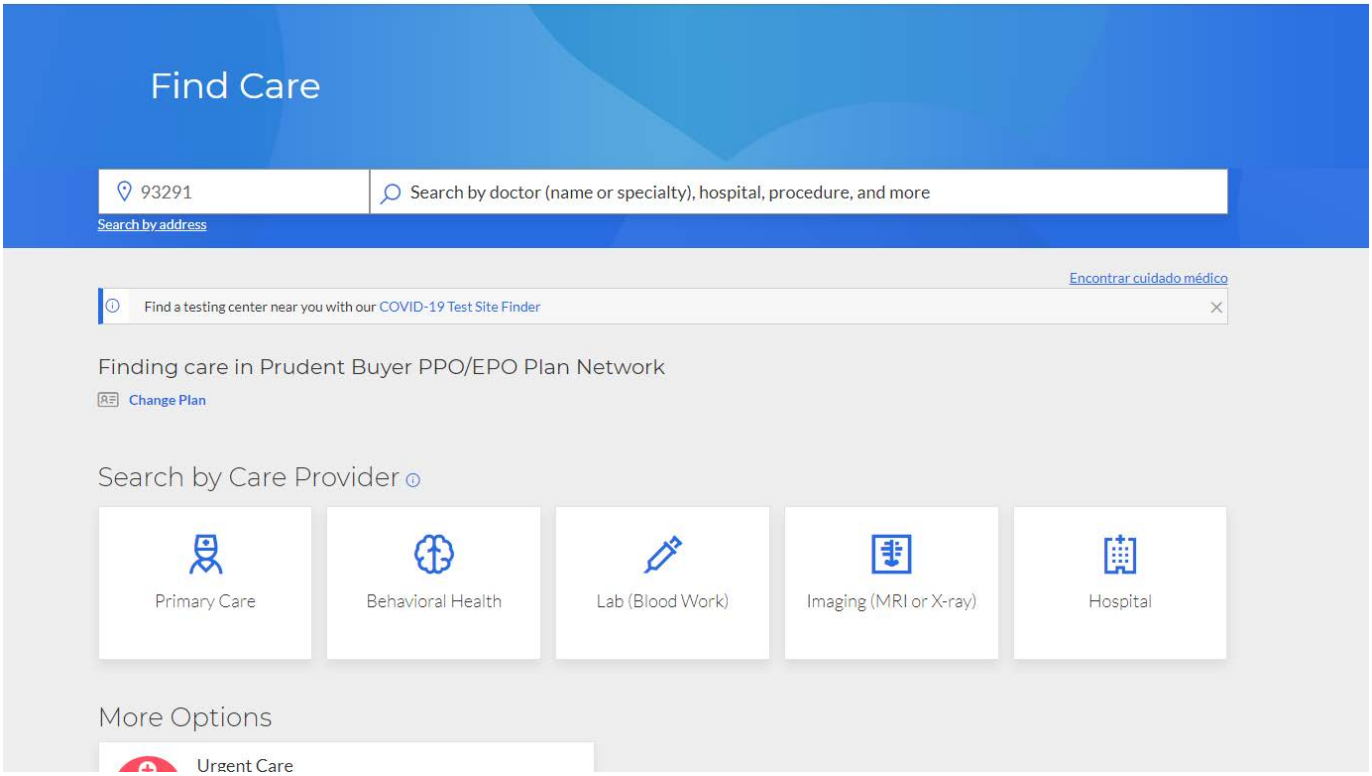
To find your physician's name and ID number (both are required on your application for the HMO plan), please follow the steps below.

Go to Anthem Find Care website: **https://findcare.anthem.com/search-providers**
Click link for "Basic search as guest"

Enter the selections as listed below:

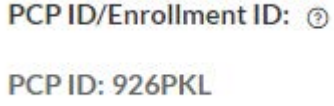


When you get to the “Find Care” screen, enter the provider name or the zip code you want to search



When you find your doctor click “View Details”

Find the PCP ID Enrollment Number and include that with your provider information.



Medical Benefits

Administered by Kaiser- INTRODUCING A NEW KAISER $1,500 HMO PLAN FOR THE 2026 PLAN YEAR

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through Tulare County Probation Association.

Tulare County Probation Association offers you a choice of one (1) HMO medical plan through Kaiser.

	DHMO Plan 19449
	In-Network
Lifetime Benefit Maximum	Unlimited
Annual Deductible	$1,500 single / $1,500 Individual in a family & $3,000 total
Annual Out-of-Pocket Maximum (includes deductible)	$4,000 single / $4,000 Individual in a family & $8,,000 total
Coinsurance	0%
Doctor's Office	
Primary Care Office Visit	$30 copay per visit
Specialist Office Visit	$40 copay per visit
Preventive Care (screenings, immunizations)	0%
Prescription Drugs	
Retail—Generic Drugs (30-day supply)	$15 copay per prescription
Retail—Preferred Brand Drugs (30-day supply)	$30 copay per prescription
Retail—Non-Preferred Brand Drugs (30-day supply)	$35 copay per prescription
Specialty Drugs (30-day supply)	20% up to $250 copay per prescription
Mail Order—Generic Drugs (100-day supply)	$20 copay per prescription
Mail Order—Preferred Brand Drugs (100-day supply)	$60 copay per prescription
Mail Order—Non-Preferred Brand Drugs (100-day supply)	$70 copay per prescription
Hospital Services	
Emergency Room	20% after deductible
Inpatient	20% after deductible
Outpatient Surgery	20% after deductible
Ambulance Service	$150 per trip / Deductible Waived

Medical Benefits

Administered by Kaiser

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through Tulare County Probation Association.

Tulare County Probation Association offers you a choice of one (1) HMO medical plan through Kaiser.

	DHMO Plan 8782
	In-Network
Lifetime Benefit Maximum	Unlimited
Annual Deductible	$750 single / $750 Individual in a family & $1500 total family
Annual Out-of-Pocket Maximum (includes deductible)	$3,000 single / $3,000 Individual in a family & $6,000 total family
Coinsurance	0%
Doctor's Office	
Primary Care Office Visit	$25 copay per visit
Specialist Office Visit	$25 copay per visit
Preventive Care (screenings, immunizations)	0%
Prescription Drugs	
Retail—Generic Drugs (30-day supply)	$10 copay per prescription
Retail—Preferred Brand Drugs (30-day supply)	$30 copay per prescription
Retail—Non-Preferred Brand Drugs (30-day supply)	$30 copay per prescription
Specialty Drugs (30-day supply)	20% up to $250 copay per prescription
Mail Order—Generic Drugs (100-day supply)	$20 copay per prescription
Mail Order—Preferred Brand Drugs (100-day supply)	$60 copay per prescription
Mail Order—Non-Preferred Brand Drugs (100-day supply)	$60 copay per prescription
Hospital Services	
Emergency Room	20% after deductible
Inpatient	20% after deductible
Outpatient Surgery	20% after deductible
Ambulance Service	$150 per trip / Deductible Waived

Medical Benefits (Continued)

Administered by Kaiser

	DHMO Plan 8782
	In-Network
Mental Health Services	
Inpatient Services	20% after deductible
Outpatient Services	Evaluation & Treatment: $25 copay per individual visit, $12 copay per day for group outpatient services
Substance Abuse Services	
Inpatient Services	20% after deductible
Outpatient Services	Evaluation & Treatment: $25 copay per individual visit, $12 copay per day for group outpatient services
Other Services	
Maternity Services	Same as Medical
All other maternity hospital/ physician services	Same as Medical
MRI, Most CT & PET scans	20% deductible waived, up to $150 per procedure
Physical, Occupational and Speech Therapy Services	Outpatient: $25 copay per visit
Skilled Nursing 100-day calendar year maximum	0%

Dental Benefits

Administered by MetLife

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Tulare County Probation Association dental benefit plans.

	All Active Full Time Employees (30 Hours)	All Active Retiree Employees (30 Hours)
Services	**In-Network and Out-of-Network**	**In-Network and Out-of-Network**
Annual Deductible	$50 per person; $150 family limit	$50 per person; $150 family limit
Annual Benefit Maximum	$2,000	$2,000
Preventive Dental Services (Examinations, Cleanings, Space Maintainers, Fluoride, Bitewing X-Rays, Periapical X-Rays)	100%	100%
Basic Dental Services (Sealants, Full Mouth X-Rays, Consultations, Amalgam Fillings, Root Canal, Periodontal Maintenance, Periodontal Surgery, Scaling & Root Planing, Prefabricated Crowns, Labs & Other Tests, Pulpotomy, Pulp Capping, Pulp Therapy, Apexification & Recalcification, Periodontics – Non-Surgical, Oral Surgery: Surgical Extractions)	80% after deductible	80% after deductible
Major Dental Services (Crown Buildups / Post Core, Repairs, Recementations, Dentures, Immediate Temporary Dentures – Complete)	50% after deductible	50% after deductible
Orthodontia Services (covered to age 19)	50% to $1,000 lifetime maximum	50% to $1,000 lifetime maximum

BASE VISION PLAN
Exam 1 x 12 mos / Lenses 1 x 12 mos / Frames 1 x 24 mos

Vision Benefits

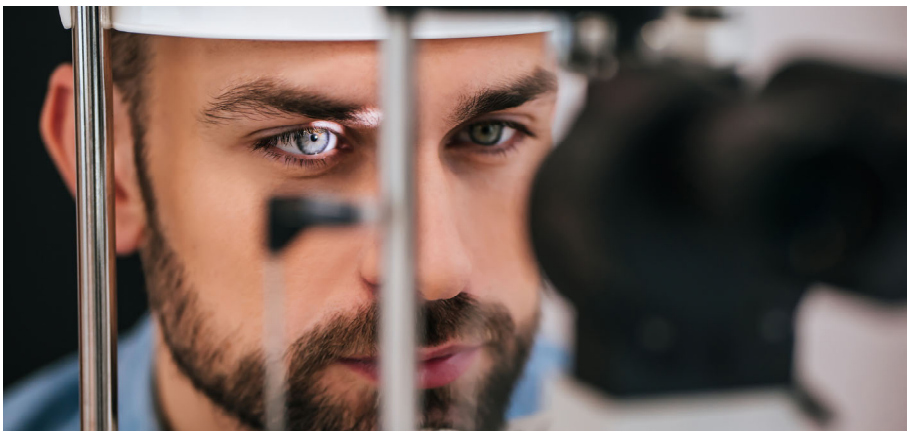
Administered by MetLife

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

Your coverage from a MetLife doctor

All Active Full Time Employees - base plan (30 Hours)

Service	In-Network (any MetLife provider)	Out-of-Network (any qualified non-network provider of your choice)
Eye Exam — once every 12 months	$0 copay	Up to $45
Lenses — once every 12 months		
Single Vision Lenses	$25 copay	Up to $30
Lined Bifocal Lenses	$25 copay	Up to $50
Lined Trifocal Lenses	$25 copay	Up to $65
Lenticular Lenses	$25 copay	Up to $100
Frames — once every 24 months	$130 allowance (additional 20%)	Up to $70
Contact Lenses — once every 12 months if you elect contacts instead of lenses/frames		
Elective	$130 allowance	Up to $105
Necessary	Covered in full	Up to $210



Vision Benefits

Administered by MetLife

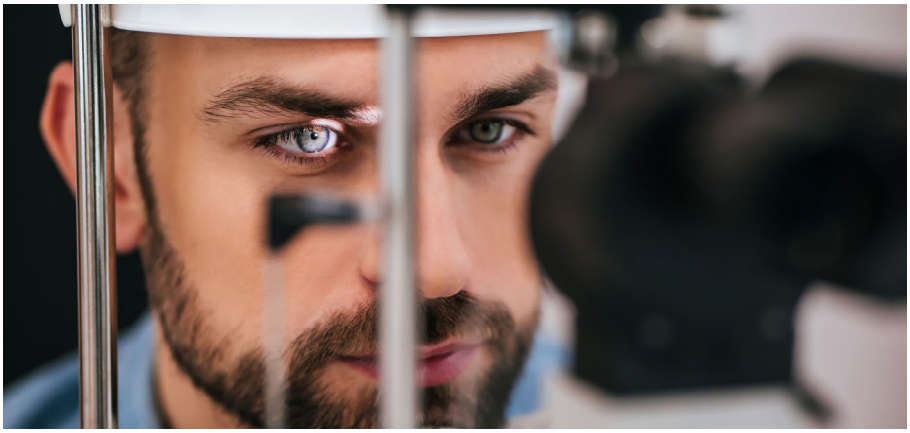
BUY UP VISION PLAN
Exam 1 x 12 mos / Lenses 1 x 12 mos / Frames 1 x 12 mos

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

Your coverage from a MetLife doctor

All Active Full Time Employees - high plan (30 Hours)

Service	In-Network (any MetLife provider)	Out-of-Network (any qualified non-network provider of your choice)
Eye Exam — once every 12 months	$0 copay	Up to $45
Lenses — once every 12 months		
Single Vision Lenses	$25 copay	Up to $30
Lined Bifocal Lenses	$25 copay	Up to $50
Lined Trifocal Lenses	$25 copay	Up to $65
Lenticular Lenses	$25 copay	Up to $100
Frames — once every 12 months	$130 allowance (additional 20%)	Up to $70
Contact Lenses — once every 12 months if you elect contacts instead of lenses/frames		
Elective	$130 allowance	Up to $105
Necessary	Covered in full	Up to $210



Tulare County Probation Association
2026 Plan Rates & Contributions w/ BASE Vision plan

Tulare County Probation Association 2026 Plan Rates and Contributions - BASE PLAN VISION									
Anthem Blue Cross $500 Deductible Plan Metlife Dental & Base Vision Plan	2025 Total of All Benefits Per Pay Period	2025 Employee Contribution Per Pay Period	2026 Medical Monthly Rates	2026 Dental Monthly Rates	2026 Vision Monthly Rates	2026 Total All Benefits Monthly Rates	2026 Total all Benefits Per Paycheck	2026 County Contribution Per Paycheck	2026 EE Deductions Per Paycheck
Employee	$399.27	$18.00	$812.69	$36.69	$5.85	$855.23	$427.62	$431.27	$0.00
Employee & Spouse	$623.66	$172.39	$1,249.75	$73.06	$11.70	$1,334.51	$667.26	$501.27	$165.99
Employee & Child(Children)	$515.17	$63.90	$1,004.80	$81.89	$13.75	$1,100.44	$550.22	$501.27	$48.95
Employee & Family	$763.14	$311.87	$1,481.99	$126.60	$21.08	$1,629.67	$814.84	$501.27	$313.57
Anthem Blue Cross $1000 Deductible Plan Metlife Dental & Base Vision Plan	2025 Total of All Benefits Per Pay Period	2025 Employee Contribution Per Pay Period	2026 Medical Monthly Rates	2026 Dental Monthly Rates	2026 Vision Monthly Rates	2026 Total All Benefits Monthly Rates	2026 Total all Benefits Per Paycheck	2026 County Contribution Per Paycheck	2026 EE Deductions Per Paycheck
Employee	$374.01	$0.00	$758.39	$36.69	$5.85	$800.93	$400.47	$431.27	$0.00
Employee & Spouse	$597.55	$146.28	$1,193.61	$73.06	$11.70	$1,278.37	$639.19	$501.27	$137.92
Employee & Child(Children)	$490.51	$39.24	$951.79	$81.89	$13.75	$1,047.43	$523.72	$501.27	$22.45
Employee & Family	$709.04	$257.77	$1,365.69	$126.60	$21.08	$1,513.37	$756.69	$501.27	$255.42
Anthem Blue Cross Premier HMO $20 Copay Metlife Dental & Base Vision Plan	2025 Total of All Benefits Per Pay Period	2025 Employee Contribution Per Pay Period	2026 Medical Monthly Rates	2026 Dental Monthly Rates	2026 Vision Monthly Rates	2026 Total All Benefits Monthly Rates	2026 Total all Benefits Per Paycheck	2026 County Contribution Per Paycheck	2026 EE Deductions Per Paycheck
Employee	$451.36	$40.08	$860.18	$36.69	$5.85	$902.72	$451.36	$431.27	$20.09
Employee & Spouse	$856.58	$348.51	$1,628.39	$73.06	$11.70	$1,713.15	$856.58	$501.27	$355.31
Employee & Child(Children)	$723.52	$225.11	$1,351.39	$81.89	$13.75	$1,447.03	$723.52	$501.27	$222.25
Employee & Family	$1,066.76	$546.22	$1,985.84	$126.60	$21.08	$2,133.52	$1,066.76	$501.27	$565.49
Kaiser DHMO $750 $20 Metlife Dental & Base Vision Plan	2025 Total of All Benefits Per Pay Period	2025 Employee Contribution Per Pay Period	2026 Medical Monthly Rates	2026 Dental Monthly Rates	2026 Vision Monthly Rates	2026 Total All Benefits Monthly Rates	2026 Total all Benefits Per Paycheck	2026 County Contribution Per Paycheck	2026 EE Deductions Per Paycheck
Employee	$517.57	$157.25	$1,149.49	$36.69	$5.85	$1,192.03	$596.02	$431.27	$164.75
Employee & Spouse	$786.40	$366.98	$1,724.24	$73.06	$11.70	$1,809.00	$904.50	$501.27	$403.23
Employee & Child(Children)	$642.48	$217.25	$1,379.39	$81.89	$13.75	$1,475.03	$737.52	$501.27	$236.25
Employee & Family	$965.74	$553.61	$2,069.08	$126.60	$21.08	$2,216.76	$1,108.38	$501.27	$607.11

Tulare County Probation Association
2026 Rates & Contributions w/ BUY-UP Vision plan

Tulare County Probation Association 2026 Plan Rates and Contributions - BUY-UP PLAN VISION									
Anthem Blue Cross $500 Deductible Plan Metlife Dental & Buy-Up Vision Plan	2025 Total of All Benefits Per Pay Period	2025 Employee Contribution Per Pay Period	2026 Medical Monthly Rates	2026 Dental Monthly Rates	2026 Vision Monthly Rates	2026 Total All Benefits Monthly Rates	2026 Total all Benefits Per Paycheck	2026 County Contribution Per Paycheck	2026 EE Deductions Per Paycheck
Employee	$427.80	$18.18	$812.69	$36.69	$6.21	$855.59	$427.80	$431.27	$0.00
Employee & Spouse	$667.60	$172.74	$1,249.75	$73.06	$12.39	$1,335.20	$667.60	$501.27	$166.33
Employee & Child(Children)	$550.61	$64.29	$1,004.80	$81.89	$14.52	$1,101.21	$550.61	$501.27	$49.34
Employee & Family	$815.44	$312.47	$1,481.99	$126.60	$22.28	$1,630.87	$815.44	$501.27	$314.17
Anthem Blue Cross $1000 Deductible Plan Metlife Dental & Buy-Up Vision Plan	2025 Total of All Benefits Per Pay Period	2025 Employee Contribution Per Pay Period	2026 Medical Monthly Rates	2026 Dental Monthly Rates	2026 Vision Monthly Rates	2026 Total All Benefits Monthly Rates	2026 Total all Benefits Per Paycheck	2026 County Contribution Per Paycheck	2026 EE Deductions Per Paycheck
Employee	$400.65	$0.00	$758.39	$36.69	$6.21	$801.29	$400.65	$431.27	$0.00
Employee & Spouse	$639.53	$146.63	$1,193.61	$73.06	$12.39	$1,279.06	$639.53	$501.27	$138.26
Employee & Child(Children)	$524.10	$39.63	$951.79	$81.89	$14.52	$1,048.20	$524.10	$501.27	$22.83
Employee & Family	$757.29	$258.37	$1,365.69	$126.60	$22.28	$1,514.57	$757.29	$501.27	$256.02
Anthem Blue Cross Premier HMO $20 Copay Metlife Dental & Buy-Up Vision Plan	2025 Total of All Benefits Per Pay Period	2025 Employee Contribution Per Pay Period	2026 Medical Monthly Rates	2026 Dental Monthly Rates	2026 Vision Monthly Rates	2026 Total All Benefits Monthly Rates	2026 Total all Benefits Per Paycheck	2026 County Contribution Per Paycheck	2026 EE Deductions Per Paycheck
Employee	$451.54	$40.26	$860.18	$36.69	$6.21	$903.08	$451.54	$431.27	$20.27
Employee & Spouse	$856.92	$348.85	$1,628.39	$73.06	$12.39	$1,713.84	$856.92	$501.27	$355.65
Employee & Child(Children)	$723.90	$225.49	$1,351.39	$81.89	$14.52	$1,447.80	$723.90	$501.27	$222.63
Employee & Family	$1,067.36	$546.82	$1,985.84	$126.60	$22.28	$2,134.72	$1,067.36	$501.27	$566.09
Kaiser DHMO $750 $25 Metlife Dental & Buy-Up Vision Plan	2025 Total of All Benefits Per Pay Period	2025 Employee Contribution Per Pay Period	2026 Medical Monthly Rates	2026 Dental Monthly Rates	2026 Vision Monthly Rates	2026 Total All Benefits Monthly Rates	2026 Total all Benefits Per Paycheck	2026 County Contribution Per Paycheck	2026 EE Deductions Per Paycheck
Employee	$596.20	$157.43	$1,149.49	$36.69	$6.21	$1,192.39	$596.20	$431.27	$164.93
Employee & Spouse	$904.85	$367.32	$1,724.24	$73.06	$12.39	$1,809.69	$904.85	$501.27	$403.58
Employee & Child(Children)	$737.90	$217.63	$1,379.39	$81.89	$14.52	$1,475.80	$737.90	$501.27	$236.63
Employee & Family	$1,108.98	$554.21	$2,069.08	$126.60	$22.28	$2,217.96	$1,108.98	$501.27	$607.71

Tulare County Probation Association 2026 Plan Rates and Contributions - BASE PLAN VISION									
Kaiser DHMO $1,500/$30 Metlife Dental & Base Vision Plan	2025 Total of All Benefits Per Pay Period	2025 Employee Contribution Per Pay Period	2026 Medical Monthly Rates	2026 Dental Monthly Rates	2026 Vision Monthly Rates	2026 Total All Benefits Monthly Rates	2026 Total all Benefits Per Paycheck	2026 County Contribution Per Paycheck	2026 EE Deductions Per Paycheck
Employee	$517.57	$157.25	$1,077.72	$36.69	$5.85	$1,120.26	$560.13	$431.27	$128.86
Employee & Spouse	$786.40	$366.98	$1,616.59	$73.06	$11.70	$1,701.35	$850.68	$501.27	$349.41
Employee & Child(Children)	$642.48	$217.25	$1,293.27	$81.89	$13.75	$1,388.91	$694.46	$501.27	$193.19
Employee & Family	$965.74	$553.61	$1,939.90	$126.60	$21.08	$2,087.58	$1,043.79	$501.27	$542.52

Tulare County Probation Association 2026 Plan Rates and Contributions - BUY-UP PLAN VISION									
Kaiser DHMO $1,500/$30 Metlife Dental & Buy-Up Vision Plan	2025 Total of All Benefits Per Pay Period	2025 Employee Contribution Per Pay Period	2026 Medical Monthly Rates	2026 Dental Monthly Rates	2026 Vision Monthly Rates	2026 Total All Benefits Monthly Rates	2026 Total all Benefits Per Paycheck	2026 County Contribution Per Paycheck	2026 EE Deductions Per Paycheck
Employee	$560.31	$157.43	$1,077.72	$36.69	$6.21	$1,120.62	$560.31	$431.27	$129.04
Employee & Spouse	$851.02	$367.32	$1,616.59	$73.06	$12.39	$1,702.04	$851.02	$501.27	$349.75
Employee & Child(Children)	$694.84	$217.63	$1,293.27	$81.89	$14.52	$1,389.68	$694.84	$501.27	$193.57
Employee & Family	$1,044.39	$554.21	$1,939.90	$126.60	$22.28	$2,088.78	$1,044.39	$501.27	$543.12

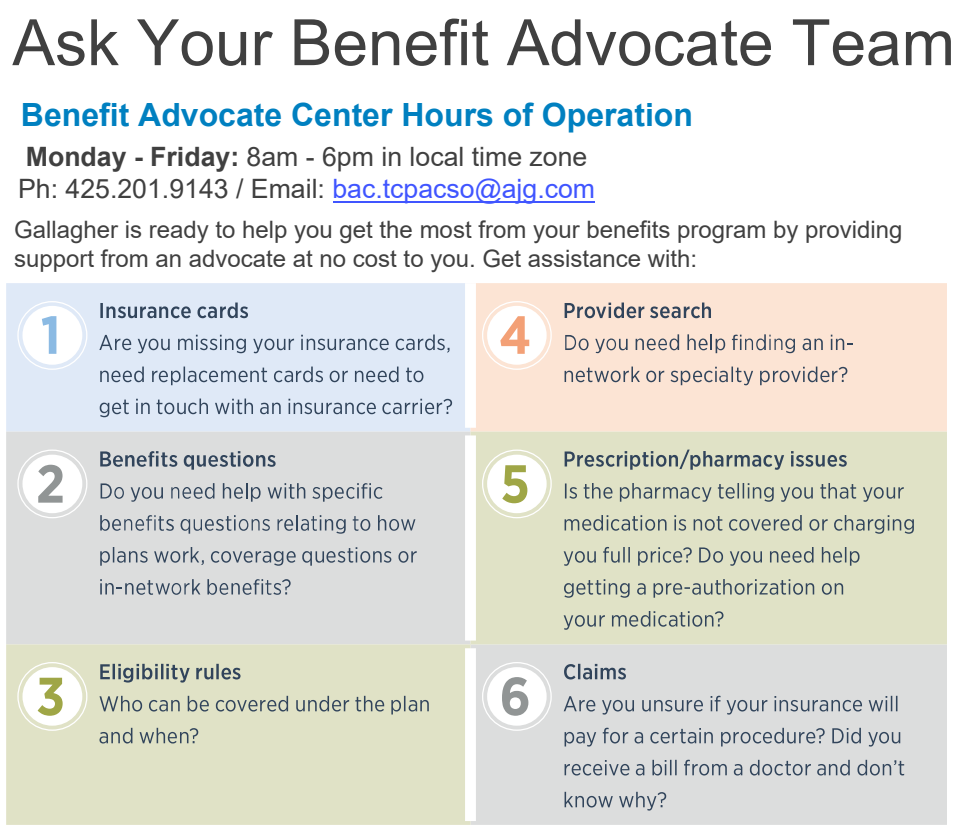
Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

Benefit	Administrator	Phone	Website/Email
Medical	Anthem Kaiser	855.333.5730 1.800.278.3296	www.anthem.com/ca www.kp.org
Dental	MetLife	1.855.638.3931	www.metlife.com
Vision	MetLife	1.855.638.3931	www.metlife.com
Benefit Advocate Center (BAC)	Gallagher	425.201.9143	bac.tcpacso@ajg.com

Gallagher Benefit Advocate Center (BAC)

How we can help you:



Legal Notices

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Anthem Premier HMO 20/100% (Individual: 0% coinsurance and $0 deductible; Family: 0% coinsurance and $0 deductible)
Plan 2: Anthem Classic PPO 500/20/40/20 (Individual: 20% coinsurance and $500 deductible; Family: 20% coinsurance and $1,500 deductible)
Plan 3: Anthem Classic PPO 1000/35/55/20 (Individual: 20% coinsurance and $1,000 deductible; Family: 20% coinsurance and $3,000 deductible)
Plan 4: Kaiser DHMO Plan 8782 (Individual: 0% coinsurance and $750 deductible; Family: 0% coinsurance and $1,500 deductible)
Plan 5: Kaiser DHMO Plan 19449 (Individual: 0% coinsurance and $1,500 deductible; Family: 0% coinsurance and $1,500 deductible

If you would like more information on WHCRA benefits, please call your Plan Administrator at 661.586.6141 or lt.torres@tcpaunion.com.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
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	Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – 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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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 January 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Tulare County Probation Association is committed to the privacy of your health information. The administrators of the Tulare County Probation Association Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Lorena Torres – Treasurer at 661.586.6141 or lt.torres@tcpaunion.com.

HIPAA Special Enrollment Rights

Tulare County Probation Association Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Tulare County Probation Association Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Lorena Torres – Treasurer at 661.586.6141 or lt.torres@tcpaunion.com.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Notice of Creditable Coverage

Important Notice from Tulare County Probation Association

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Tulare County Probation Association and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Tulare County Probation Association has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Tulare County Probation Association coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. If you drop your current coverage and enroll in Medicare prescription drug coverage, you may enroll back into the Medical benefit plan during the Annual Enrollment period under the Medical Plan.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Tulare County Probation Association and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE**: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Tulare County Probation Association changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1□800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: January 01, 2026
Name of Entity/Sender: Tulare County Probation Association
Contact—Position/Office: Lorena Torres
Office Address: 101 E Center St.
Visalia, California 93291
United States
Phone Number: 661.586.6141

ANTHEM MEDICAL ENROLLMENT ONLY

Anthem Blue Cross Enrollment Form

Anthem.

Please return the completed enrollment form to your employer.

COMPLETE ALL HIGHLIGHTED AREAS

Effective date (MMDDYY)	Group no.
	2 8 2 0 5 1

Select One: __ Anthem HMO 20 // __ Anthem PPO 500 // __ Anthem PPO 1000

NOTE: If you elect the HMO coverage, you must list your PCP on page 3. If you do not, Anthem will assign a PCP to you.

Section 1: Applicant's personal information

Last name	First name	M.I.	Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Social Security or TIN no.[1] (required)
Mailing address		Apt. no.	No. of dependents including spouse	Spouse/DP Social Security or TIN no.[1] (required)
City		State	ZIP code	Home phone no.

Hire date/Rehire date Part-time to Full-time date (MMDDYY)	Employer name	Job title	Class	Dept. no.	Email address
	Tulare County Probation				

Language choice (optional) ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other – please specify: _____

SIMNSA Eligibility[2]: (Complete only if SIMNSA is selected as the medical group for you or any dependent.)
Are you a Mexican National? ☐ Yes ☐ No Do you work in San Diego county or Imperial county? ☐ Yes ☐ No

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.

1 TIN refers to Taxpayer Identification Number.

2 Member must meet both criteria above.

Section 2: Reason for application – Select one

☐ New enrollment
☐ Annual open enrollment (not applicable to life and disability)
☐ New hire
☐ Rehire – Rehire date: _____ (MMDDYY)
☐ Marriage – Date of marriage: _____ (MMDDYY)
☐ Domestic Partnership – Date of commencement: _____ (MMDDYY)
☐ Birth of child
☐ Add dependent (Fill in section 4)
☐ Loss of eligibility for other coverage – Date previous coverage ended: _____ (MMDDYY) (not applicable to life and disability)
☐ COBRA – Select qualifying event (not applicable to life and disability)
☐ Left employment ☐ Reduction in hours ☐ Death ☐ Medicare
☐ Loss of dependent child status ☐ Divorce or legal separation ☐ Covered employee's Medicare entitlement
Qualifying event date: _____ (MMDDYY)
☐ Waiver (To decline ALL coverage skip to section 5.)

Social Security or TIN no.[1] (required)

Section 3: Type of coverage – Select from only the coverages offered by your employer.

Medical

Anthem Blue Cross plans:

- ☐ HMO[2]
- ☐ Priority Select HMO[2]
- ☐ Select HMO[2]
- ☐ Vivity HMO[2]
- ☐ Elements Choice HMO[2]
- ☐ POS (Blue Cross Plus)[2]
- ☐ EPO (Prudent Buyer Exclusive)
- ☐ Blue Connection EPO
- ☐ Anthem High Performance EPO
- ☐ Anthem High Performance EPO HSA

Anthem Blue Cross Life and Health Insurance Company plans:

- ☐ PPO (Prudent Buyer)
- ☐ Select PPO
- ☐ Elements Choice PPO
- ☐ Elements Choice HSA (non-California resident)
- ☐ BC PPO (non-California resident)
- ☐ BC Exclusive (non-California resident)
- ☐ Consumer Driven Health Plans: (select one of the following)
  - ☐ H.S.A.[3] ☐ H.R.A.
  - ☐ H.I.A. Plus
- ☐ Medicare

☐ Other: _____

☐ Add HRA Wrap (Administered by Anthem)

2 Indicate Medical Group/IPA no. in the *Employee and family information* section 4.

3 Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

Flexible Spending Account (FSA) – More than one plan may be selected, depending on employer offerings.

☐ Healthcare FSA ☐ Limited-Purpose FSA (for members enrolled in HSA plans) ☐ Dependent Care FSA ☐ Commuter Transit ☐ Commuter Parking

Dental

Anthem Blue Cross plans:

- ☐ Dental Net HMO[4]
- ☐ Choice Dental (select one of the following)
  - ☐ Dental Net HMO[4]
  - ☐ PPO Dental

Anthem Blue Cross Life and Health Insurance Company plans:

- ☐ Dental Consumer Choice
- ☐ Dental Essential Choice
- ☐ Dental Prime
- ☐ Dental Complete
- ☐ Dental Prime Voluntary
- ☐ Dental Complete Voluntary
- ☐ Dental Consumer Choice Voluntary
- ☐ Dental Essential Choice Voluntary
- ☐ Voluntary PPO Dental
- ☐ Dental Blue Complete Incentive
- ☐ Dental Choice EPO
- ☐ Dental Choice EPO Voluntary
- ☐ Dental Blue PPO
- ☐ PPO Dental
- ☐ National Dental Blue PPO
- ☐ National PPO Dental
- ☐ National Voluntary PPO Dental

☐ Other: _____

4 Indicate Dental Office no. in *Employee and family information* section 4.

Vision

☐ Blue View Vision (offered by Anthem Blue Cross Life and Health Insurance Company)

Life and Disability Insurance

All the coverages listed may not be offered by your employer. To elect dependent coverage, the corresponding employee coverage must be selected. List all life insurance beneficiaries in the *Life insurance beneficiary designation information* section. If you select life and/or disability coverage over the guaranteed issue amount or are a late entrant an *Evidence of Insurability* form may be sent to you to complete.

Annual salary
$

Elected benefit	Benefit amount
☐ Basic Life (AD&D)	$
☐ Dependent Life – Spouse	$
☐ Dependent Life – Child	$

Elected benefit	Benefit amount
☐ Supplemental/Voluntary Life – Employee	$
☐ Supplemental/Voluntary Dependent Life – Spouse	$
☐ Supplemental/Voluntary Dependent Life – Child	$
☐ Short Term Disability	$
☐ Long Term Disability	$

Elected benefit	Benefit amount
☐ Voluntary AD&D – Employee	$
☐ Voluntary AD&D – Spouse	$
☐ Voluntary AD&D – Child	$
☐ Voluntary Short Term Disability	$
☐ Voluntary Long Term Disability	$

Group Accident, Critical Illness and Hospital Indemnity Insurance

☐ Group Accident Insurance – Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Accident plan offered please select: ☐ Low Plan ☐ High Plan

☐ Group Critical Illness Insurance – Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Critical Illness plan offered please select: ☐ Low Plan ☐ High Plan
Have you smoked or used tobacco products in the last 12 months? ☐ No ☐ Yes, explain product used: _____

☐ Group Hospital Indemnity Insurance – Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Hospital Indemnity plan offered please select: ☐ Low Plan ☐ High Plan

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.
If any person to be covered by a Critical Illness or Hospital Indemnity plan is a resident of CA, GA, NY or CO, please answer the following question:
Will all applicants who reside in CA, GA, NY, or CO, when such coverage is to become effective, be enrolled in comprehensive health benefits from an individual or group health insurance policy, an employer sponsored health plan, or an HMO that provides essential health benefits?
☐ Yes ☐ No Please note that if the response is No, such applicants are not eligible for coverage.

1 TIN refers to Taxpayer Identification Number.

Social Security or TIN no.[1] (required)

~~Group Accident, Critical Illness, and Hospital Indemnity Insurance beneficiary designation~~

~~Beneficiary designation~~ — ~~Attach a separate sheet if necessary.~~

	~~Name of beneficiary~~	~~Percentage~~	~~Social Security or TIN no.[1]~~	~~Relationship to applicant~~	~~Age~~
☐ ~~Primary~~ ☐ ~~Contingent~~					
☐ ~~Primary~~ ☐ ~~Contingent~~					
☐ ~~Primary~~ ☐ ~~Contingent~~					
☐ ~~Primary~~ ☐ ~~Contingent~~					
☐ ~~Primary~~ ☐ ~~Contingent~~					
☐ ~~Primary~~ ☐ ~~Contingent~~					

Total percentages must add up to 100%. If the total percentages add up to less than 100%, the remaining percentage will be paid in equal shares to all named beneficiaries to total 100%. If the total percentages add up to more than 100%, each named beneficiary's share will be reduced equally to total 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above. Beneficiaries may be changed by the insured's written notice to his or her employer.

Note: Enrollment in the selected plan is dependent upon you residing or working within a plan's geographical service area, and the network, provider, and physician availability within the geographical service area. If at the time of your enrollment the network or physician/medical group is not available or you do not reside or work in the geographical service area of the plan, you may be assigned to or be required to choose a different provider, network, and/or plan.

Section 4: Employee and family information — Please list yourself and all eligible family members to be enrolled. Attach additional sheets if necessary.

Sex	Last Name	First Name	M.I.	Birthdate (MM/DD/YY)	Social Security or TIN no.[1] (required)	Full-time student (if applicable, for non-medical plans)	If children are age 26 or over you must check the appropriate boxes below	HMO & POS ONLY IPA/Primary Care Physician code	Current MD?	~~Dental Net ONLY Office no.~~
☐ M ☐ F	Employee								☐ Yes ☐ No	
☐ M ☐ F	Spouse/DP						IRS Qualified Dependent		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	

1 TIN refers to Taxpayer Identification Number.

COMPLETE ONLY IF WAIVING COVERAGE

Social Security or TIN no.[1] (required)

Section 5: Declination — Please complete if any coverage is declined or refused by an eligible employee and/or their eligible dependents.

A. Medical coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

~~B. Dental coverage declined for:~~
☐ Myself ☐ Spouse/DP ☐ Child(ren)

~~C. Vision coverage declined for:~~
☐ Myself ☐ Spouse/DP ☐ Child(ren)

~~D. Life insurance coverage declined for:~~
☐ Myself ☐ Spouse/DP ☐ Child(ren)

~~E. Disability insurance coverage declined for:~~
☐ Myself

Reason for declining coverage — check one
☐ Covered by spouse's group coverage
Insurer name and ID no.: _____
☐ Covered by Anthem Individual policy
☐ Spouse covered by employer's group medical coverage
Insurer name: _____
☐ Enrolled in Tricare
☐ Enrolled in any other insurance plan
Insurer name: _____
☐ Medicare
☐ Other (Explain): _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT PERIOD TO BE ENROLLED IN THIS GROUP MEDICAL AND/OR GROUP LIFE INSURANCE PLAN.**

Signature if declining coverage for employee/dependent(s)
X

Date (MMDDYY)

SIGN ONLY IF WAIVING COVERAGE

Section 6: COBRA/Cal-COBRA coverage information — Complete only if enrolling in COBRA/Cal-COBRA.

Reason for COBRA/Cal-COBRA coverage

Federal COBRA qualifying event date (MMDDYY)	Federal COBRA coverage begin date (MMDDYY)	Federal COBRA coverage end date (MMDDYY)
Cal-COBRA qualifying event date (MMDDYY)	Cal-COBRA coverage begin date (MMDDYY)	Cal-COBRA coverage end date (MMDDYY)

Section 7: Other coverage for all enrolling employees and dependents — All questions must be answered.

A. Do any persons on this application intend to continue other group coverage if this application is accepted? ☐ Yes ☐ No
If yes, name of person(s): _____
Insurance company: _____ Policy no. _____ Phone no. _____

B. Does any person applying for coverage currently have health insurance coverage? ☐ Yes ☐ No
Has any person applying for coverage had health insurance coverage at any time in the past six months? ☐ Yes ☐ No
If yes, applicant/family member name(s): _____
Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____
Insurance company: _____ Policy no. _____ Phone no. _____
Date coverage began: _____ Date ended: _____ (MMDDYY)

C. Does any person applying for coverage currently have dental insurance coverage? ☐ Yes ☐ No
If yes, applicant/family member name(s): _____
Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____ Includes orthodontia? ☐ Yes ☐ No
Insurance company: _____ Policy no. _____ Phone no. _____
Date coverage began: _____ Date ended: _____ (MMDDYY)

D. Does any person applying for coverage currently have vision insurance coverage? ☐ Yes ☐ No
If yes, applicant/family member name(s): _____
Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____
Insurance company: _____ Policy no. _____ Phone no. _____
Date coverage began: _____ Date ended: _____ (MMDDYY)

E. Is any person applying for coverage eligible for Medicare or currently receiving Medicare benefits? ☐ Yes ☐ No
Note: If you are eligible for Medicare, Anthem may not duplicate Medicare benefits.

1 TIN refers to Taxpayer Identification Number.

Social Security or TIN no.[1] (required)

Section 9: Prior coverage for PPO and dental plans only — Attach additional sheets if necessary.

Please fill out the following information to receive proper credit for previous coverage (if immediately prior to becoming eligible for this plan, you have a dependent child(ren) over the age of 26 who cannot get a self-sustaining job due to a physical or mental condition and was covered under any public or private health care coverage, including MediCal or individual coverage). Note: If this section is left blank, there may be delays in the processing of claims for these dependents. If any coverage will remain in force once your dependent(s) enroll with Anthem, leave the end date blank.

Name (last, first, M.I.)	Type (check one)	Coverage (check all that apply)	Insurer name	Insurer phone no.	Policy ID no.	Date (if applicable) (MMDDYY)	Reason for ending coverage (if applicable)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: End:	
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: End:	
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: End:	

~~Section 10: Life insurance beneficiary designation information~~

~~**Beneficiary designation** — Attach a separate sheet if necessary.~~
~~Primary Beneficiary — First to receive payment (required)~~

~~**Note:** Dependent Life payments are always paid to the employee.~~

	~~Name of beneficiary~~	~~Percentage~~	~~Social Security or TIN no.[1]~~	~~Relationship to applicant~~	~~Age~~
☐ ~~Primary~~ ☐ ~~Contingent~~					
☐ ~~Primary~~ ☐ ~~Contingent~~					
☐ ~~Primary~~ ☐ ~~Contingent~~					
☐ ~~Primary~~ ☐ ~~Contingent~~					
☐ ~~Primary~~ ☐ ~~Contingent~~					

Total percentages must add up to 100%. If the total percentages add up to less than 100%, the remaining percentage will be paid in equal shares to all named beneficiaries to total 100%. If the total percentages add up to more than 100%, each named beneficiary's share will be reduced equally to total 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above. Beneficiaries may be changed by the insured's written notice to his or her employer.

Spousal Consent For Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse consent for designation.)
If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA, and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following.
Authorization: I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy.
I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws.
I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.
In CA, NV, and WA, Spouse also includes your registered Domestic Partner.

~~Spouse/Domestic Partner signature~~	~~Spouse/Domestic Partner name~~	~~Date (MMDDYYYY)~~
X		

Section 11: Electronic notice — Signature required to opt-in to electronic delivery.

Member email address: _____

I (primary applicant) agree to receive my plan-related communications for myself and any dependents, either by email or electronically. This may include my certificate, evidence of coverage, explanation of benefits statements, required notices or helpful information to get the most out of my plan. I agree to provide and update Anthem with my current email address. I know that at any time I can change my mind and request a copy of these materials (or any specific materials) by mail, by contacting Anthem. I or my enrolled dependents will update our communication preferences by going to anthem.com/ca or calling Member Services at 877-242-5659.

Member signature	Date (MMDDYY)
X	

1 TIN refers to Taxpayer Identification Number.

SIGNATURE REQUIRED ON THIS PAGE IF ELECTING COVERAGE

Social Security or TIN no.[1] (required)

Section 12: Please read carefully — Signature required.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

Deduction authorization: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

Non-participating provider: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

HIV testing prohibited: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

Effective date: The effective date of coverage is subject to Anthem approval.

COBRA/Cal-COBRA Continuation Coverage

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

1. The date eligibility for COBRA Continuation Coverage ends, or
2. The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
3. The date your employer discontinues coverage with Anthem, or
4. The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
5. The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information.

The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

I certify each Social Security number listed on this application is correct.

Life and/or Disability Authorization Section – Read carefully before signing

1. Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.
2. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.
3. This authorization, for purposes of processing this application form, is valid from the date signed for a period of 30 months unless revoked by me in writing, which I may do at any time by contacting Anthem. For the purpose of collecting information in connection with a claim for benefits under an insurance policy, this authorization shall remain valid for the term of coverage of the policy for an accident and sickness insurance benefit and for the duration of the claim if the claim is not for an accident and sickness insurance benefit. A photocopy and/or electronic copy is as valid as the original. The Applicant or the Applicant's authorized representative is entitled to receive a copy of this Authorization.
4. I give this authorization for myself and on behalf of my eligible dependents if covered by the Plan, including my Spouse/Domestic Partner/Civil Union Partner. I am acting as their agent and representative.

REQUIREMENT FOR BINDING ARBITRATION (Not applicable to Life and Disability coverage)

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY (ANTHEM), INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: ***It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.*** **YOU AND ANTHEM AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU.** Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "handwritten or electronic" signature below, you acknowledge that such signature is valid and binding.

Signature (Required)

Applicant	Date (MMDDYY)
X	

1 TIN refers to Taxpayer Identification Number.

KAISER ENROLLMENT/CHANGE FORM

California Subscriber Enrollment/Change Form

Company and Subscriber information

Please print in blue or black ink only. **COMPLETE ALL ITEMS HIGHLIGHTED IN YELLOW**

A. Company information (to be completed by administrator)

Number of pages including this page

Company name: **Tulare County Probation Association**

Customer ID*

Enrollment unit ID*

Enrollment unit name/classification

Eligibility contact phone

Plan (example: HMO 20, DHMO 500/30): **600791 Traditional HMO NCR**

Employee Number

Effective date of enrollment/change* (mm/dd/yyyy)

Reason for enrollment if adding subscriber and/or dependent(s)

- ☐ Open enrollment period
- ☐ Birth of eligible dependent
- ☐ Newly eligible, new hire, rehire, or increase in hours
- ☐ Special enrollment period (as described under "Additional information" on page 2) due to triggering event on (mm/dd/yyyy)

B. What are the changes requested? (subscriber mark the box for each change you are requesting)

- ☐ Enroll subscriber (and dependents)
- ☐ Add dependent(s) to existing subscriber account
- ☐ Remove dependent(s) from subscriber account
- ☐ Change name of subscriber and/or dependent(s)
- ☐ Update address
- ☐ Other

C. Subscriber/employee information

Notice: California law prohibits an HIV test from being required or used by health care service plans/health insurance companies as a condition of obtaining coverage/health insurance coverage.

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No Gender:* ☐ Male ☐ Female

First name*

MI*

Medical record number (if known)

Last name*

Social Security number*

Former name/nickname

Date of birth (mm/dd/yyyy)

Home address* (physical location, no P.O. Box)

City*

State*

ZIP code*

Phone

Mailing address (if different than home)

City

State

ZIP code

D. Signature (please sign at the bottom of this page in the box below for subscriber signature)

Kaiser Foundation Health Plan Arbitration Agreement.† I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

X

Subscriber signature*

Date (mm/dd/yyyy)

*Field required for all enrollments and changes. †Disputes arising from the following fully insured Kaiser Permanente Insurance Company coverages are not subject to binding arbitration: 1) the Preferred Provider Organization (PPO) and the Out-of-Network portion of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.

KAISER PERMANENTE®

Subscriber's last name*

Subscriber's medical record (if known)

Dependent information page(s)

Use this page to enroll, remove, or update dependents. Multiple dependent information pages may be used, if space is needed for additional dependents. **Sections A–D on the Customer and Subscriber information page are required for all requests.**

E. Dependents

1 ☐ Enroll ☐ Remove ☐ Change name Relationship to subscriber: ☐ Spouse ☐ Domestic partner ☐ Dependent child

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No

Gender:* ☐ Male ☐ Female

First name*

MI*

Medical record number (if known)

Last name*

Social Security number*

Former name/nickname

Date of birth (mm/dd/yyyy)

2 ☐ Enroll ☐ Remove ☐ Change name Relationship to subscriber: ☐ Spouse ☐ Domestic partner ☐ Dependent child

Has this person ever received treatment at a Kaiser Permanente facility? ☐ Yes ☐ No

Gender:* ☐ Male ☐ Female

First name*

MI*

Medical record number (if known)

Last name*

Social Security number*

Former name/nickname

Date of birth (mm/dd/yyyy)

Additional information

Name(s) of covered dependent(s) that live at a different address than subscriber

Home address* (physical location, no P.O. Box)

City

State

ZIP code

The following special enrollment information applies to coverage under a small group plan: If you decline coverage for yourself or an eligible dependent when you are first eligible to enroll, you can only enroll or change your coverage during an annual open enrollment period established by your employer, or during a special enrollment period if you have experienced a triggering event. You must request coverage within 60 days of a triggering event. Special enrollment triggering events include:

- Loss of health care (minimal essential) coverage, resulting from any of the following: loss of employer-sponsored coverage because you and/or your dependent no longer meet the eligibility requirements, or your employer no longer offers coverage or stops contributing premium payments; loss of eligibility for COBRA coverage (for a reason other than termination for cause or nonpayment of premium); your and/or your dependent's individual, Medi-Cal, Medicare, or other governmental coverage ends; or for any reason other than failure to pay premiums on a timely basis or situations allowing for a rescission (fraud or intentional misrepresentation of material fact); or loss of health care coverage including, but not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code;
- Gaining or becoming a dependent due to marriage, domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship;
- A valid state or federal court orders that you or your dependent be covered;
- Permanent relocation, such as moving to a new location and having a different choice of health plans, or being released from incarceration;
- The prior health coverage issuer substantially violated a material provision of the health coverage contract;
- A network provider's participation in your and/or your dependent's health plan ended when you and/or your dependent(s) were under active care for one of the following conditions: an acute condition (an acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration); a serious chronic condition (a serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration); pregnancy; terminal illness (a terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less); care of a newborn child between birth and age 36 months; or performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured;
- A member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code;
- An individual demonstrates to the Department of Managed Health Care or Department of Insurance, as applicable, with respect to health benefit plans offered outside the Exchange that the individual did not enroll in a health benefit plan during the immediately preceding enrollment period available because the individual was misinformed that he or she was covered under minimum essential coverage.

*Field required for all enrollments and changes.

DENTAL AND VISION ENROLLMENT ONLY
COMPLETE ALL HIGHLIGHTED AREAS

MetLife
Metropolitan Life Insurance Company, New York, NY 10166

ENROLLMENT • CHANGE FORM

SECTION 1: Group Customer Information *(To be Completed by the Recordkeeper)*

Name of Group Customer/Employer	Group Customer Number	Division	Class	Dept Code
TCPAdba Tulare County Corrections Assoc Union	5397991			

Date of hire *(mm/dd/yyyy)* | Coverage Effective Date *(mm/dd/yyyy)*

Original COBRA Effective Date *(if applicable, mm/dd/yyyy)* | COBRA Termination Date *(if applicable, mm/dd/yyyy)*

SECTION 2: Your Enrollment Information *(To be Completed by the Employee in blue or black ink)*

First Name | Middle Name | Last Name

SSN | Date of birth *(mm/dd/yyyy)* | Gender: ☐ Male ☐ Female | Marital status: ☐ Single ☐ Married

Address | City | State | ZIP

Job title | Hours worked per week

☐ New Enrollment ☐ Change in Enrollment ☐ COBRA Continuation
If due to a Qualifying Event, enter date *(mm/dd/yyyy)*

Phone number | Email address

- I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below.
- The following disclosure is required by New Mexico law: **This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.**
- If you are enrolling after the initial enrollment period, please refer to the Declarations and Signature section of this enrollment form to determine the evidence of insurability and late entrant requirements. If evidence of insurability is required for a coverage you are electing, you must complete a Statement of Health form for all amounts you are requesting.

GEF02-1
ADM
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF02-1
ADM *applies to residents of North Dakota and Utah)*

Dental Insurance

☐ Dental Option

Select your level of coverage

☐ Employee Only
☐ Employee + Spouse/Domestic Partner[1]
☐ Employee + Child(ren)
☐ Employee + Spouse/Domestic Partner[1] + Child(ren)

Vision Insurance

☐ Vision Dual Option

First select your option	Then select your level of coverage
☐ High Option	☐ Employee Only
☐ Low Option	☐ Employee + Spouse/Domestic Partner[1]
	☐ Employee + Child(ren)
	☐ Employee + Spouse/Domestic Partner[1] + Child(ren)

[1] Domestic Partner includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available. It also includes your non-registered Domestic Partner if you and your Domestic Partner have either a substantial interest in the other engendered by love and affection; or a lawful and substantial economic interest in the continued life, health or bodily safety of each other, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the other person. By enrolling such Domestic Partner for coverage and signing this enrollment form, you are attesting to such relationship.

GEF02-1
ADM
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF02-1
ADM *applies to residents of North Dakota and Utah)*

SECTION 3: Dependent Information

If you are applying for coverages for your Spouse/Domestic Partner and/or Child(ren), please provide the information requested below.

Name of your Spouse/Domestic Partner *(first, middle, last)*	Date of birth *(mm/dd/yyyy)*	
		☐ Male ☐ Female
Name(s) of your Child(ren) *(first, middle, last)*	Date of birth *(mm/dd/yyyy)*	
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

GEF02-1
ADM
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GEF02-1
ADM *applies to residents of North Dakota and Utah)*

SECTION 4: Fraud Warnings

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.
Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies to the extent required by applicable law.
Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.
Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.
Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

GEF09-1a
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF09-1
FW *applies to residents of North Dakota and Utah)*

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.
New York (only applies to Accident and Health Insurance): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.
Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.
Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.
Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

GEF09-1a
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GEF09-1
FW *applies to residents of North Dakota and Utah)*

SECTION 5: Declarations and Signature

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling.
3. I understand that if I do not enroll for dental coverage during the initial enrollment period, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired. I understand that if I do not enroll for vision coverage during the initial enrollment period, I cannot enroll for such coverage until the next annual enrollment period.
4. I understand that if I do not sign the payment authorization below, coverage for which contributions are required will not take effect until I have provided such authorization.

GEF09-1a
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GEF09-1
DEC *applies to residents of North Dakota and Utah)*

5. I affirmatively decline coverage for any benefits for which I am eligible which I do not request on this enrollment form.
6. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here Signature of Employee | Date signed *(mm/dd/yyyy)*

Print First Name | Print Middle Name | Print Last Name

PAYMENT AUTHORIZATION

By signing below, I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.

Sign Here Signature of Employee | Date signed *(mm/dd/yyyy)*

Print First Name | Print Middle Name | Print Last Name

GEF09-1a
(The form number above applies to residents of all states except as follows: Form number **GEF09-1** *applies to residents of Montana;*
GEF09-1
DEC *applies to residents of North Dakota and Utah)*

How to submit this form

After completion, make a copy for your records and return the original to your employer.

HUMAN RESOURCES & DEVELOPMENT
TULARE COUNTY

EFFECTIVE DATE:
RECEIVED BY:
ENTRY DATE:

County of Tulare
2026 Health Plan Opt-Out Form

Employees may elect to waive enrollment in the County's health insurance coverage in any given Plan Year. Employees who elect to waive enrollment in the County's health insurance coverage must provide evidence the Employee and the Employee's tax dependents have or will have minimum essential coverage (MEC) other than individual market coverage during the Plan Year. Employees who elect to waive enrollment may receive an opt-out payment (cash-in-lieu) (varies by bargaining unit). An election to opt out shall be irrevocable for the Plan Year, except as outlined in Section 5.6 of the Tulare County Section 125 Benefits Plan.

Cash-in-lieu of medical benefits will not be made if the County knows or has reason to know that the employee or family member does not or will not have MEC.

Please complete and return this form **ONLY** if you are opting out of coverage (not electing) the following health plans: County of Tulare (through SJVIA), Tulare County Probation Association (TCPA), or Tulare County Deputy Sheriff's Association (TCDSA).

PART ONE EMPLOYEE INFORMATION

Employee Name (Last, First, MI)	Employee ID

PART TWO WAIVING COVERAGE

If you are declining enrollment for yourself, or your dependents (spouse/registered domestic partner/children) because you have coverage under another medical plan, you may be able to enroll yourself or your dependents in a County of Tulare medical plan in the future, provided you request enrollment within thirty (30) days after your other coverage ends.

In order to qualify for this special enrollment period, you must certify other coverage was the reason for declining enrollment and provide verification of the source of that other coverage.

DECLINATION OF COVERAGE: The available medical coverage has been explained to me by my employer. I have been given a chance to apply for the available medical coverage. I have decided not to enroll myself and/or my eligible dependents in the County's medical coverage. I am covered as an eligible subscriber or dependent under the insurance described below.

Please note: Written proof of other medical coverage must accompany this form.

I certify that I have other medical coverage ***(check one box and specify in Part Three***):

- ❑ Through another County of Tulare employee (Employee Name/ID): _____
- ❑ Outside of the County of Tulare Group Health Plan through Spouse/RDP or Parent (specify below)
- ❑ Other health coverage (specify below)

PART THREE OTHER HEALTH COVERAGE

Insurance Carrier Name: _____

Employer/Group Name: _____

Type of Plan (i.e. HMO, PPO): _____

Insured/Primary Subscriber Name: _____

PART FOUR EMPLOYEE CERTIFICATION AND SIGNATURE

I understand that if I do not gain special enrollment rights upon a loss of other coverage, my next opportunity to enroll in a County of Tulare medical plan will be the next annual open enrollment period, unless special enrollment rights apply. I understand that I am also waiving medical, dental, vision, prescription drugs, and mental health coverage. I agree to notify my employer promptly if I or any of my dependents loses this alternative coverage, and I understand cash-in-lieu payments will be stopped at that time. I also understand that I will be required to attest to this alternative coverage each plan year I decline coverage under my employer's group medical plan.

By signing below, I certify that the reason I am declining coverage is accurate as indicated by the check marks above. I certify that by not electing to participate in the County of Tulare's health insurance coverage, I am not subject to any court order or legal obligation to provide health insurance for my dependents.

Signature: _____ Date: _____

Forms and supporting documentation may be emailed to lt.torres@tcpaunion.com.

Notes

Notes

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.