2024

RETIREE BENEFITS OVERVIEW




Your Benefits, Your Choice.

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Introduction to your 2024 Benefit Guide

Welcome to the 2024 Retiree Benefits Guide! Whether you are planning your retirement or if you have already retired from the County, we hope that you find the information in the Guide informative and useful. This Guide is intended to be a summary of benefits offered to you and your family in retirement (mainly health benefits).

All benefits are subject to change and there is no guarantee that these benefits will be continued indefinitely. The benefit descriptions are very general and are not intended to provide complete details about any or all plans. Exact specifications for all plans are included in the official Plan Documents, copies of which are available online at https://www.smcgov.org/hr/health-benefits or available at the Benefits Office (455 County Center 5th Floor, Redwood City, CA 94063).

Feel free to contact the County's Benefits Division at 650-363-1919, via email at benefits@smcgov.org or visit https://hr.smcgov.org/retiree-health-benefits-current-retirees if you have any questions about retiree health benefits.

Thank you.

The Benefits Team

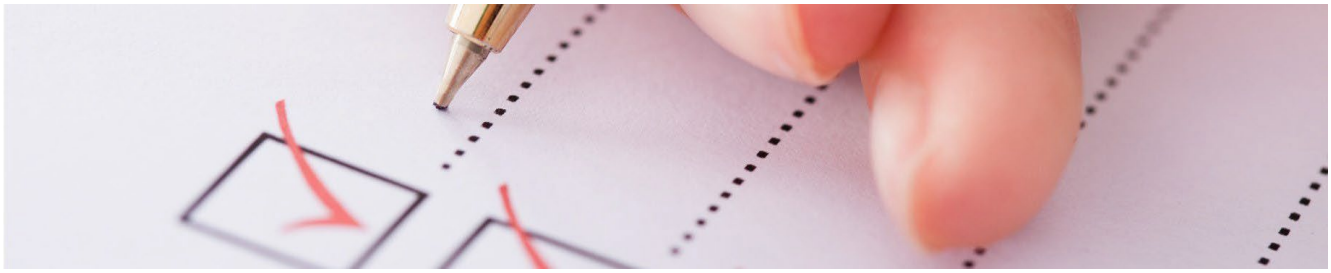
What's New in 2024?

Over-The-Counter (OTC) Wellness Benefit for Medicare members enrolled in the California Kaiser Permanente Senior Advantage Plan (KPSA)

Starting 1/1/2024, the County's KPSA Medicare HMO plan will include a $70 quarterly benefit for OTC health and wellness products delivered to their home at no additional cost

OTC health and wellness product includes:	**Starting 1/1/2024, eligible members can get their order by:**
• Vitamins and minerals • Allergy, cough, and cold remedies • Antacids, laxatives, and stomach aids • Pain reliever and fever reducers • First aid kits, joint support, and incontinence products • Blood pressure monitor and thermometers. • Diabetic supplies such as compression stockings and sharp containers	• Visiting kp.org/otc/ca • Calling 1-833-569-2360 (TTY 711) Monday through Friday 7 am to 6 pm

Retiree Health FAQs



Does the County offer health benefits to retirees?

Yes, the County offers medical and dental plans for retirees similar to those offered to active employees. In addition, the County maintains medical plans for retirees and their dependents that have become Medicare eligible. There is no retiree health benefit for “deferred retirements”.

Am I eligible for retiree health benefits?

The rules pertaining to retiree health benefits are included in the applicable Memorandum of Understanding (MOU) or Board Resolution for your employee group (union). The MOUs and Resolutions are posted on the County’s website at https://hr.smcgov.org/employee-and-labor-relations or in the Summary of Health Benefits section of this guide.

Generally speaking, any employee who retires from the SamCERA system can continue their group health plan coverage under a County Retiree health plan. Coverage must be continuous, meaning that an employee cannot retire and then decide to enroll in a County plan at a later time.

When are retiree health benefits effective?

Active benefits terminate on last day of the month following your termination date, and retiree health benefits commence on first day of the month following termination date.

When/how do I enroll in retiree health benefits?

If you want to continue your health coverage and enroll in one of the County's group retiree health plans, you must enroll within 30 days prior to your retirement date. With the exception of a pending disability retirement, if you do not enroll by your retirement date, you will have waived your right to continue your County coverage under a group plan. You will also have waived your right to use any sick leave hours accumulated as an active employee toward the cost of your retiree health insurance.

Please contact the County's Benefits Division at 650-363-1919 or via email at benefits@smcgov.org to schedule an appointment with a Benefits staff member approximately 30 days prior to your retirement date. At that meeting, a Benefits Partner will explain your retiree health options and answer any of your questions. You will also be asked to complete and sign the "Retiree Health Enrollment Form" at the back of this Benefits Guide.

Retiree Health FAQs

HEALTH PLAN OPTIONS IN RETIREMENT

What medical plan options do I have in retirement?

If you are under 65 years old, your plan options are the same as an active employee: Kaiser HMO, Aetna HMO, Aetna Value Network (AVN) HMO , Aetna OAMC, Aetna High Deductible Health Plan, Kaiser High Deductible Health Plan.

If you are over 65 years old, your Medicare plan options are Kaiser Senior Advantage HMO and Aetna Medicare® PPO. **(High Deductible plans are not available once you are on Medicare.)**

What is the County's Alternate Health Plan?

If you move out of an existing HMO coverage area and you have remaining sick leave credits, you have the option of enrolling in the County's Alternate Health Plan. Under this plan, you enroll in a major medical plan comparable to the plan options offered under the County's benefit package. The County pays a monthly contribution for your elected coverage. The payment is made via direct deposit into the account of your choice. The amount you will be reimbursed depends on the value of your sick leave hours but no more than the total cost of your monthly premium for the plan you have selected. It is important to remember that these payments are taxable income. Also, proof of other coverage is required (copy of your health plan card and proof of premium cost) on a yearly basis. You can always move back to a County plan at Open Enrollment or during a qualifying life event as long as there has been continuous coverage under the Alternate Health Plan and you still have available sick leave hours.

What are my options for medical, dental and vision insurance?

Based on your bargaining group's Memorandum of Understanding, you may be able to retire and keep your medical, dental, and vision plans. If your MOU does not allow you to keep all three plans and you opt to keep your County's medical plan, you may continue your dental coverage for 18 months through COBRA, or you can enroll in one of the County's Retiree Voluntary dental and vision plans.

For more information on COBRA, please refer to the Important Plan Notices and Documents section of this guide.

IMPORTANT NOTE:

If you retiring within the next 12 months, buy up plans will not carryover in retirement unless you opt to pay for the full premium on COBRA for 18 months maximum.* Once you leave the County's dental plan and you opt for COBRA, you will only be eligible to enroll in the County's retiree voluntary dental plan.

Retiree Health FAQs

Can I keep my County life insurance in retirement?

If you wish to continue to be covered for life insurance, you may choose to port coverage to another group term life policy or convert your coverage to an individual policy. Note that the cost of continued coverage if you port to another group policy is generally less than if you convert to an individual whole life policy. You have 30 days from the date of termination to continue life insurance in retirement. Contact Standard Life Insurance at 800-628-8600 for more information.

Can I keep my money invested in Empower (formerly MassMutual) Deferred Compensation Account?

As a retiree, you can retain your 457 deferred compensation funds with the County's plan or you can roll the funds to another plan. You can also roll funds into your 457 plan. Contact Empower at 1-800-528-9009 for more information or visit www.viewmyretirement.com/sanmateocounty

COST OF RETIREE BENEFITS

Will the County help pay for my retiree health premiums?

If you enroll in a retiree health plan through the County, the County will contribute to your monthly retiree health premiums only if you have unused sick leave available when you retire. According to your MOU, the County may provide you with additional sick leave hours based on your years of service or if you retire due to a disability.

What if I don't have any sick leave when I retire or what happens when my sick leave credits expire?

You may still continue your County medical plan. However, you would be required to pay the full cost of the premium.

Retiree Health FAQs

How are sick leave credits used to pay for my health insurance in retirement?

Generally, 8 hours of unused sick leave pays for a portion of your County retiree health premium. In other words, if you have 96 hours of sick leave left at retirement, the County will pay a portion of your monthly premium for 12 months (96 divided by 8). Once your sick leave is exhausted, you can remain on the County's plan. However, you would be required to pay the full cost of the premium.

Some MOU's allow you to use less or more than 8 hours of sick leave per month. Changing the value of your sick leave can only occur at Open Enrollment or within 31 days of a qualifying life event.

How much will the County contribute toward my insurance premiums each month?

The County's monthly contribution toward health insurance premiums varies by bargaining group. Generally, 8 hours of unused sick leave equals between $400 and $700 based on your group's MOU, Board Resolution and your years of County service.

The amount of sick leave hours that you can use per month depends on your group's MOU or Board Resolution. The higher amount of sick leave hours you elect has a greater County contribution to your monthly premium. However, using a higher amount of hours would mean that your sick leave balance will exhaust faster. You can change your sick leave credits at Open Enrollment or within 31 days of a qualifying life event.

Example:

Retiree A and B have 120 hours of sick leave at retirement and are in the same bargaining unit. Retiree A chooses to use 8 hours of sick. Retiree B chooses to use 14 hours of sick leave. The County's contribution to Retiree B is higher because she is using more sick leave credits per month. However, the duration of the County's contribution to Retiree B's premiums will be shorter than the duration of the County's contribution to Retiree A.

	Retiree A	**Retiree B**
Sick leave at retirement	120 hours	120 hours
Sick leave credits used per month	8 credits	14 credits
County contribution per month	$400	$700
Duration of County contribution	15 months	9 months

For illustrative purposes only

Retiree Health FAQs

Additional information about retiree health benefits by bargaining group is located later in this guide. Complete details on an employee's retiree health benefits can be found in that employee's applicable Memorandum of Understanding located on the County's website at http://hr.smcgov.org/employee-and-labor-relations.

How do I pay for my insurance premiums?

If you retired before January 1, 2017, have a signed authorization, and already have a deduction from your pension check

- If you are using your sick leave credit to partially pay for your medical premiums, SamCERA will automatically deduct your premiums from your pension check.
- Once your sick leave credits have been exhausted and you want to pay for your premiums in full, you will receive a letter from Benefits Coordinators Corporation (BCC) with instructions on how you can pay for your premiums.

If you retired after January 1, 2017

- Bank account information will be required to deduct your monthly premium from the account that you noted on the Electronic Fund Transfer form.

- The County's 3rd party administrator for retiree health, Benefit Coordinators Corporation (BCC) will deduct your applicable premium one to two days after your pension is deposited.

Is my deduction for health insurance pre-tax?

No, all health insurance deductions for retirees are post-tax.

Am I taxed on the County's contribution to my retiree health insurance?

No, the County's contribution to your insurance is not included in a retiree's taxable income. There is one exception to this rule:

- Alternate Health Plan –For retirees who move out-of-area and opt for the Alternate Health Plan (discussed in more detail later in this Guide), the monthly County contribution is deposited in the retiree's bank account. This amount becomes taxable to the retiree.

Does the County's contribution cover my dependents?

Most MOU's allow retirees to apply the County's contribution toward coverage for retiree, spouse/domestic partner, or children up to age 26.

Retiree Health FAQs

If I don't want or need to use sick leave toward retiree health coverage, can I cash out my sick leave?

Unfortunately, the County prohibits employees from cashing out sick leave. If you don't use your hours towards either health or dental, you lose those hours.

Do the premiums change every year?

Yes. Although the County aggressively negotiates health plan renewals in an effort to control increasing benefit costs for retirees, health insurance premiums typically increase between 5% and 12% every year. Factors fueling increased costs include: increased use of new medical technologies, higher prescription drug costs, pressure on health insurance plans and the private sector to absorb higher costs as funding for public programs like Medicare and Medicaid decreases, and increased utilization due to the economic environment.

What are the current health premiums?

Please see the cost section of this guide for current medical and dental premiums.

OPTIONS FOR ENROLLING DEPENDENTS

Who is eligible to be on my retiree plan?

- Your current spouse or domestic partner.
- Your natural children, stepchildren, domestic partner's children, foster and/or adopted children under 26 years of age
- Your disabled children age 26 or older.
- A tax-qualified dependent

This is a brief description of the eligibility requirements and is not intended to modify or supersede the requirements of the plan documents. The plan documents will govern in the event of any conflict between this description and the plan documents.

Retiree Health FAQs

How can I make changes to my retiree health outside of Open Enrollment?

You must complete and submit the Retiree Change Form with the required documentation to the Benefits Division within 31 days of the qualifying life event.

All changes will become effective first of the following month upon receipt of the completed change form.

Retiree Health Change Forms can be obtained by contacting Benefits Division at 650-363-1919, via email at benefits@smcgov.org or visit https://hr.smcgov.org/retiree-health-benefits-current-retirees.

When can I add or remove my dependents?

You are responsible for notifying the Benefits Division to update your dependent status during the plan year by completing the Retiree Change Form (marriage, birth, death, divorce, dissolution of domestic partnership, ineligibility of dependent child due to age/school status, etc.). Such notification must be made within 31 days that the status change occurs. Failure to submit the change form in a timely manner may impact dependent eligibility for health care continuation under COBRA, and may result in you incurring liability for medical expenses for non-eligible dependents.

MAKING CHANGES TO MY PLANS

When can I cancel my coverage?

You may cancel your coverage at any time by submitting a completed Retiree Change Form via email at benefits@smcgov.org or fax at (650)599-1573. A Medicare Disenrollment Form may be required if you are cancelling your County's Medicare coverage. The effective date of your cancellation will generally be the first of the following month. Please note that once you cancel your medical coverage you cannot re-enroll back into a County health plan in the future.

What if I move out of the area during retirement?

If you move out of the area, you may need to switch to a different health plan that offers coverage in your new area. Contact Benefits Division at 650-363-1919 to assist you with this transition.

Can I switch my plan during annual Open Enrollment?

Yes, retirees can only switch plans during Open Enrollment in October unless they experience a qualifying life event (moving out of the service area).

Can I switch my plan at retirement?

No, the plan that you are enrolled in as an active employee is the same plan you will have when you retire. You will need to wait until Open Enrollment unless you are moving out of the HMO service area.

Retiree Health FAQs

Can my benefits change when I'm in retirement?

The County's contribution amount based on your sick leave credits do not change. This is set at the time you retire. What can change are the types of plans that are offered to retirees and the plan design (co-pay amounts, deductibles etc.).

Can I add/drop dependents to my health plan?

You may add/drop eligible dependents during the year if you experience a qualifying life event, i.e. death of a spouse, divorce, marriage, domestic partnership, birth of a child, etc. Any change to benefits must be made within 31 days of a qualifying life event and completed Retiree Change form and required documentation must be submitted to Benefits Division. Otherwise you may only make changes during the annual Open Enrollment period.

When does my coverage as an active employee end?

Upon retirement, your medical, dental and vision plan coverage as an active employee ends on the last day of the month following your date of retirement or loss of eligibility. Your coverage ends on the date of your retirement for your Flexible Spending Accounts, Group Life/AD&D, Long Term Disability, and Employee Assistance Program.

Can I cancel my benefits anytime?

As a retiree, you have the option of terminating your health coverage at any time. Once you decide to terminate coverage, however, you will forfeit the option of ever opting back in to the retirement health plans. You will only be eligible for the Voluntary Dental or Vision Plans.

TERMINATION OF VOLUNTARY DENTAL AND VISION PLAN PROVISION:

- Retirees who are cancelled because of non-payment of premiums will be excluded from participation in any of the Retiree Voluntary Benefits Plans in the future and will waive their right to enroll in any of the Retiree Voluntary Benefits Plans in the future.
- Please note: Enrollment in any of the voluntary plans requires a 12-month calendar year enrollment period from January 2024-December 2024.

About Medicare

Where do I find out about my medical benefits with Medicare?

If you are approaching 65 and reaching eligibility for Medicare, you will need to be aware of the transition process and any action that might be required on your part. The best resource for finding out about Medicare is the official publication, "Medicare & You", published annually by The Centers for Medicare and Medicaid Services (CMS). You can find this publication and other valuable information at www.Medicare.gov. You can also look in the Retiree Guide Benefits for Retirees Over 65.

What happens when I or one of my dependents become Medicare eligible?

Once retired, individuals must enroll in Medicare Part A and B three (3) months before their 65th birthday or risk paying a penalty to Social Security. You and your eligible family members must enroll in Medicare Part A and B or you will be dropped from coverage. The Benefits Division will send you a reminder letter 3 months prior to your or your covered dependents 65th birthday.

How do I enroll in Medicare?

About three (3) months before your 65th birthday, the Social Security office will send you information about enrolling in Medicare. You must enroll in both Medicare Part A (hospital coverage) and Part B (Outpatient coverage). You do not enroll in Part D (prescription drugs) because this benefit is already included in the County's plans.

Once you are enrolled in Medicare, you will need to choose from one of the Medicare plans (Kaiser Senior Advantage, or the Aetna Medicare® PPO). You will need to complete an enrollment application form for the plan you elect. The enrollment form along with a copy of your Medicare Card showing both Medicare Part A and Part B must be returned to the County's Benefit Office benefits@smcgov.org or faxed to (650)599-1573 prior to enrollment in the plan.

It is critical that you complete and submit this form before your 65th birthday. If you do not enroll in Medicare Part B during your Special Enrollment Period, you'll have to wait until the next General Enrollment Period, which is January 1 through March 31 of each year. You may then have to pay a higher Medicare Part B premium because you did not enroll in a timely manner.

About Medicare

What is an "Advantage" plan?

An Advantage plan is a managed care or HMO plan in which you "assign" your Medicare. Assigning your Medicare means that you are enrolled in Medicare through the plan (Kaiser Senior Advantage or Aetna Medicare® PPO). This means that when you choose to enroll in Kaiser Senior Advantage or Aetna Medicare® PPO, you assign your Medicare to the insurance plan. This means that Kaiser or Aetna provides your Medicare Parts A and B coverage.

Do I need both my Medicare Card and my Kaiser or Aetna Medicare® PPO ID Card when I see medical services?

You only need your Kaiser or Aetna Medicare® PPO ID Card. Your Medicare card is not needed for all Medicare plans.

Do I need to pay Part B premiums as a retiree on a County plan?

Yes. Part B premiums are set every year by the social security office. In order to remain on a County Medicare plan, you must pay your Part B premiums to the Social Security Office.

What if my spouse turns 65 before me?

If your spouse turns 65 before you, your spouse will receive a letter 3 months before their 65th birthday requesting a copy of the Medicare card and application for one of our Medicare plans. Once received, you will automatically be adjusted to a "split plan" upon receipt of your spouse's Medicare application and copy of the Medicare Card. You will remain in a non-Medicare plan and your spouse will be enrolled in the Medicare plan which may reduce your premium costs.

About Medicare

What are the options for Split Coverage Families?

Split families are those families that may have some members eligible for Medicare and some members who are not.

Employees 65 or over (Medicare-eligible) with Dependents under 65 (non-Medicare)

- **If you elect the Aetna Medicare® PPO plan**, your non-Medicare dependents would go on either the Active Aetna OAMC plan, or the Active AVN or HMO plans.
- **If you elect the Kaiser Senior Advantage Plan**, your non-Medicare dependents would stay on the Kaiser Active plan. The Senior Advantage plan is almost identical to Active plan.

Employees under 65 (non-Medicare) with Dependent(s) over 65 (Medicare-eligible)

- **If you are on the Active Aetna AVN or HMO plans**, your Medicare–eligible dependents would go on the Aetna Medicare® PPO plan.
- **If you are on the Active Kaiser plan,** your Medicare-eligible dependents would go on the Kaiser Senior Advantage plan.

Summary of Retiree Health Benefits

This is intended to be a summary of the County's retiree health benefits. Complete details on an employee's retiree health benefits can be found in that employee's applicable Memorandum of Understanding located on the County's website at www.co.sanmateo.ca.us/hr (click on Employee and Labor Relations).

Represented Group	Retiree Health Benefit
American Federation of State, County and Municipal Employees (AFSCME) – COURTS Service Employees International Union SEIU) Law Enforcement Unit (LEU) – Deputy Sheriff's (Non-Safety) San Mateo County Council of Engineers (SMCCE) Building Construction Trades Council (BCTC)	If hired prior to January 1, 2011 for AFSCME (January 23, 2011 for SEIU, and July 10, 2011 for SMCCE, BCTC, DSA non-safety-LEU) If the employee has 10-14 years of service, the County pays $440 toward the monthly premium for one plan (either health or dental) for every 8 hours of sick leave remaining upon retirement. The employee can use up to 14 hours of sick leave to pay for the monthly premium, and can enroll in the other plans through COBRA. If the employee has more than 20 years of service, the 8-hour sick leave conversion is reduced to 6 hours. Employees are credited with additional sick leave hours based on years of service. There may be an inflation factor of 2% for employees with 15-19 years of service and 4% for employees with 20+ years. If hired on/after January 1, 2011 for AFSCME (January 23, 2011 for SEIU, and July 10, 2011 for SMCCE, BCTC, DSA non-safety- LEU) County pays $400 toward the monthly premium for one plan (either health or dental) for every 8 hours of sick leave remaining upon retirement. The employee can use up to 14 hours of sick leave to pay for the monthly premium, and can enroll in other plans through COBRA. Employees are credited with additional sick leave hours based on years of service. There may be an inflation factor of 2% for employees with 15-19 years of service and 4% for employees with 20+ years.

Summary of Retiree Health Benefits

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Represented Group	Retiree Health Benefit
American Federation of State, County and Municipal Employees (AFSCME) – COUNTY ONLY	If hired prior to June 11, 2022 retired on or after 6/12/2022 Post-65 and Pre-65 Benefit A monthly County contribution is provided based on years of service and age. This contribution can be used towards County medical, dental and/or vision plan premium Any remaining contribution amount that remains AFTER the premium/s is paid in full will be deposited into the retiree's RHRA on a monthly basis If not enrolled in a County retiree benefit plan/s, the full monthly contribution will be deposited into the retiree's RHRA on a monthly basis f hired on/after June 12, 2022 All employees will pay a bi-weekly contribution of $25 into their RHRA account. After 5 years of continuous service under an AFSCME (County) union, the County will deposit a contribution of $3000 into their RHRA and the County will begin paying a bi-weekly County contribution of $25 bi-weekly into the employee's RHRA A time of retirement, employees can opt to keep the County medical, dental and vision and pay the full cost of premiums with the option to use their RHRA fund to offset the monthly premium cost

Summary of Retiree Health Benefits

Represented Group	Retiree Health Benefit
Union of American Physicians and Dentists (UAPD)	County pays $400 toward the monthly premium for one plan (either health, or dental or vision) for every 8 hours of sick leave remaining upon retirement. The employee can use up to 14 hours of sick leave to pay for the monthly premium, and can enroll in other plans through COBRA.
California Nurses Association (CNA) and Licensed Vocational Nurses (in AFSCME)	The County pays the full cost of the "Retiree Only" monthly premium for the retiree health plan for every 8 hours of sick leave remaining upon retirement up to a maximum of 240 months (for Licensed Vocational Nurses the maximum is 180 months). The employee can enroll in the dental and vision plans through COBRA.
Management, Confidential, Attorneys, Elected Officials	If hired before April 1, 2008 The County pays the full cost of the retiree + family monthly premium for the health, dental and vision plans for every 8 hours of sick leave remaining upon retirement. The employee can keep all three County plans in retirement. If hired between April 1, 2008 and December 31, 2010 The County pays $700 toward the monthly premium for the retiree health plan for every 8 hours of sick leave remaining upon retirement. The employee can keep all three County plans in retirement. The County pays the full cost of the dental and vision premiums for every 8 hours of sick leave upon retirement. The County also contributes $100 per month per employee to a post-employment health reimbursement account on a pre-tax basis. Upon retirement or termination, payments made for eligible premiums or medical expenses are not taxed. If hired on/after January 1, 2011 The County pays $400 toward the monthly premium for the retiree health plan for every 8 hours of sick leave remaining upon retirement.

Summary of Retiree Health Benefits

Represented Group	Retiree Health Benefit
Management, Confidential, Attorneys, Elected Officials	Elected Officials hired on/after January 1, 2011 For elective officers who retire concurrently with separation from County service, for each month of County service, the County will pay $400 toward the premium for one month of the retiree health plan and the full cost of one month of the dental and vision coverage.
Probation and Detention Association (PDA) Deputy Sheriff's Association (Safety) (DSA) Organization of Sheriff's Sergeants (OSS)	If hired prior to (1/8/2023 for PDA, 2/5/2023 DSA and OSS) and retired on or after (1/8/2023 for PDA and 2/5/2023 for DSA and OSS) Pre-65 Benefit A monthly County contribution is provided based on years of service and age. This contribution can be used towards County medical, dental and/or vision plan premium Any remaining contribution amount that remains AFTER the premium/s is paid in full will be deposited into the retiree's RHRA on a monthly basis If not enrolled in a County retiree benefit plan/s, the full monthly contribution will be deposited into the retiree's RHRA on a monthly basis fIf hired after (1/8/2023 for PDA, 2/5/2023 DSA and OSS) All employees will pay a bi-weekly contribution of $25 into their RHRA account. After 5 years of continuous service under an AFSCME (County) union, the County will deposit a contribution of $3000 into their RHRA and the County will begin paying a bi-weekly County contribution of $25 bi-weekly into the employee's RHRA A time of retirement, employees can opt to keep the County medical, dental and vision and pay the full cost of premiums with the option to use their RHRA fund to offset the monthly premium cost

Medical Benefits for Retirees Under 65

The County's medical plans are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. For Early Retirees, the County offers a choice of medical plans through **Aetna and Kaiser Permanente.**

aetna™

- **HMO** – a Health Maintenance Organization (HMO) in which patients seek medical care from a doctor participating in the plan's network. If you join Aetna, you select a PCP and medical group within Aetna's network of doctors. Most services and medicines are covered with a small co-payment. Any specialty care you need will be coordinated by your PCP/medical group and will require a referral or authorization. More information about Aetna's health plan benefits is available at https://www.smcgov.org/hr/health-benefits; click on Medical Plans.
- **Aetna Value Network (AVN) HMO –** The Aetna Value Network (AVN) plan is also an HMO, but the provider network is only in California and Nevada and is comprised of a preferred list of medical groups. In all other aspects though the AVN plan works the same as the HMO described above.
- **OAMC PPO ($200 Deductible)** – a Preferred Provider (PPO) plan that allows members the choice and flexibility to receive medical services from an in-network doctor or out-of-network doctor.
    - **In Network**: Medical services are provided through the Aetna Managed Choice POS (Open Access) network (OAMC for short). You are responsible for paying an annual deductible and a percentage of the cost of the services (generally 20% of Aetna's allowable amount).
    - **Out-of-network**: This allows you to access services through any licensed doctor or hospital. You are responsible for paying a deductible and a higher annual percentage of the cost of care (generally 40% of Aetna's allowable amount).

- **High Deductible Health Plan** -** This is a plan that works in conjunction with a Health Savings Account. You use the same OAMC Network that you would under the standard plan. All of your preventative services are covered in full. You pay for the entire cost of non-preventive services until you satisfy your annual deductible. From that point, you pay 10% of the cost for non-preventive services until you reach your Calendar Year Maximum. At that point, do not pay out of pocket for any services the rest of the year.

Medical Benefits for Retirees Under 65

KAISER PERMANENTE®

Kaiser Permanente Traditional HMO – a Health Maintenance Organization (HMO) in which patients seek medical care within the plan's own facilities. Under this plan, most services and medicines are covered with a small co-payment. You select your doctor, or Primary Care Provider (PCP), from the staff at a local Kaiser Permanente facility. All of your care is provided at a Kaiser facility. Services outside of a Kaiser facility are not covered except if it is a life-threatening emergency.

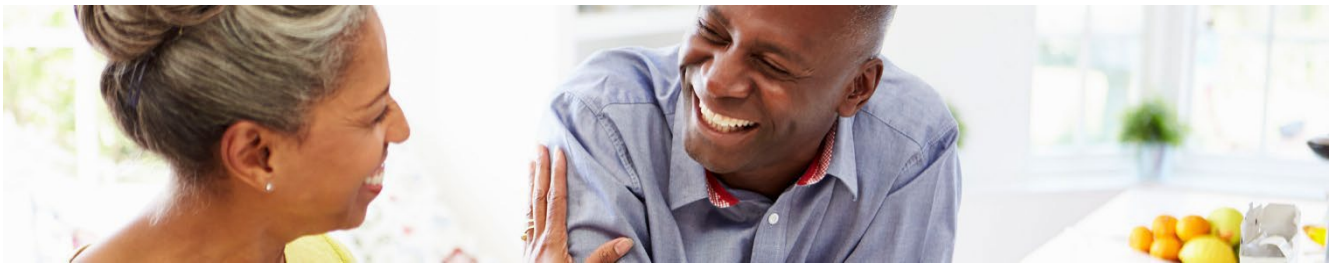
Kaiser Permanente High Deductible Health Plan** - This is a plan that works in conjunction with a Health Savings Account (please see the Health Savings Account section of this guide). You use the same Kaiser facilities that you would under the standard Kaiser plan. All of your Preventative services are covered in full. You pay for the entire cost of non-preventive services until you satisfy your annual deductible. From that point, you pay 10% of the cost for non-preventive services until you reach your Calendar Year Maximum. At that point, do not pay out of pocket for any services for the rest of the year.

****Note:** If you have a Health Saving Account as an active employee, your account will move to a retail account with Avidia Bank upon retirement. You will receive your new login information to review and manage your account. You will also receive a new debit card from Avidia Bank to access the balance in your retail account.

You can no longer access your HSA through BCC/SmartCare after retirement.

For more information, you may contact Avidia Bank at:
Avidia Bank
42 Main St
Hudson, MA 01749
(855) 248-6311
hsainfo@avidiabank.com
www.avidiabank.com

Medical Benefits for Retirees Over 65



Aetna Medicare® Plan (PPO) with Extended Service Area – a Preferred Provider Organization with Extended Service Area which gives you the flexibility to see any licensed provider or hospital nationwide. Your cost is the same for any provider in or out of network, as long as they accept Medicare and your Aetna plan. You have the option to choose a Primary Care Provider (PCP), but it is not required. No referrals are needed. This plan also includes Medicare Part D prescription coverage. Most services and medications are covered with a small co-payment.

Kaiser Permanente Senior Advantage– a Health Maintenance Organization (HMO) in which patients seek medical care within the plan's own facilities. Under this plan, most services and medicines are covered with a small co-payment. You select your doctor, or Primary Care Provider (PCP), from the staff at a local Kaiser Permanente facility. All of your care is provided at a Kaiser facility. Services outside of a Kaiser facility are not covered except if it is a life-threatening emergency. Early Retirees can remain on the Kaiser plan; once you reach age 65, you will need to enroll in the Kaiser Senior Advantage plan.

Comparison of HMO Plans

UNDER 65

	Aetna		Kaiser Permanente	
	HMO	AVN	Traditional HMO	HDHP
	In-Network	In-Network	In-Network	In-Network
Annual Deductible	$0 per individual $0 family limit	$0 per individual $0 family limit	$0 per individual $0 family limit	$1,600 per individual $3,200 (per member in a family of two or more) $3,200 family limit
Annual Out-of-Pocket Max Individual Family	$1,000 $3,000	$1,000 $3,000	$1,500 $3,000	$3,000 per individual $3,000 (per member in a family of two or more) $6,000 family limit
Physician/Professional Services				
Office Visits Physician & Specialist	$15 copay	$15 copay	$15 copay	Plan pays 90% after deductible
Designated Walk-in Clinic Visit (e.g., CVS HealthHUB or CVS MinuteClinic)	$0 copay	$0 copay	Not applicable	Not applicable
Telemedicine	$15 copay	$15 copay	No charge	No charge
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Chiropractic and Acupuncture Care	$10 copay (up to 30 visits per year)	$10 copay (up to 30 visits per year)	$15 copay (up to 20 visits per year)	Not covered
Lab and X-ray	Plan pays 100%	Plan pays 100%	$5 copay then plan pays 100%	Plan pays 90% after deductible
Infertility (Please refer to the EOC for additional details)				
Diagnosis and treatment of infertility	Diagnosis and treatment of the underlying medical condition only. (Your cost sharing is based on the type of service and where it is performed)	Diagnosis and treatment of the underlying medical condition only. (Your cost sharing is based on the type of service and where it is performed)	50% coinsurance	50% coinsurance after deductible
Assisted reproductive technology (“ART”) Services	Not Covered	Not Covered	50% coinsurance	50% coinsurance after deductible
Family Planning				
Physicians Family Planning Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Vasectomy	Cost shared based on where performed	Cost shared based on where performed	$50 per procedure	Plan pays 90% after deductible
Tubal Ligation	Plan pays 100%	Plan pays 100%	$50 per procedure	Plan pays 90% after deductible

This document is intended as a quick reference, not a comprehensive description. Limitations and exclusions can be found in the official plan documents. In case of any discrepancies, the official plan documents will govern

Comparison of HMO Plans

UNDER 65

	Aetna		Kaiser Permanente	
	HMO	AVN	Traditional HMO	HDHP
	In-Network	In-Network	In-Network	In-Network
Hospital Benefits				
Inpatient Hospitalization	$100 admission copay	$100 admission copay	$100 admission copay	Plan pays 90% after deductible
Outpatient Surgery	$50 copay	$50 copay	$50 copay	Plan pays 90% after deductible
Urgent Care	$15 copay	$15 copay	$15 copay	Plan pays 90% after deductible
Emergency Room	$100 copay (waived if admitted)	$100 copay (waived if admitted)	$100 copay (waived if admitted)	Plan pays 90% after deductible
Mental Health Services				
Inpatient Hospital	$100 per admission	$100 per admission	$100 per admission	Plan pays 90% after deductible
Outpatient	$15 copay	$15 copay	$15 copay; $7 group	Plan pays 90% after deductible
Substance Abuse Services				
Inpatient Hospital	$100 per admission	$100 per admission	$100 per admission	Plan pays 90% after deductible
Residential Care	$100 per admission	$100 per admission	$100 per admission	Plan pays 90% after deductible
Outpatient	$15 copay	$15 copay	$15 copay; $5 group	Plan pays 90% after deductible
Other Services				
Transgender	Covered (see plan document for limitations)	Covered (see plan document for limitations)	Covered (see plan document for limitations)	Covered (see plan document for limitations)
Durable Medical Equipment	No charge	No charge	20% coinsurance	Plan pays 90% after deductible
Orthotic and Prosthetic Devices	No charge	No charge	No charge	No charge after deductible
Skilled Nursing Facility Up to 100 days per Member, per Benefit Period	No charge	No charge	No charge	Plan pays 90% after deductible

[1] New employees hired between December 2022 through November 2024 can receive a $900 incentive by enrolling in the Aetna Value Network (AVN) HMO during new hire benefits election.

This summary is intended as a quick reference not a comprehensive description. For more plan information, please go to Benefits Employee's website at https://www.smcgov.org/hr/health-benefits.

Prescription Drugs

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

	Aetna		Kaiser Permanente	
	HMO	AVN	Traditional HMO	HDHP
	In-Network	**In-Network**	**In-Network**	**In-Network** (After Plan Deductible)
Pharmacy				
$0 Chronic Drug List	Plan pays 100% for Aetna Value Drug list	Plan pays 100% for Aetna Value Drug list	Plan pays 100%	Plan pays 100%
Preferred Generic	$15 per prescription	$15 per prescription	$10 per prescription	$10 per prescription
Preferred Brand	$25 per prescription	$25 per prescription	$20 per prescription	$30 per prescription
Non-Preferred Generic and Brand	$40 per prescription	$40 per prescription	$20 per prescription	$30 per prescription
Specialty Drugs	20% up to $200 max. copay/prescription; must use Aetna's Specialty Rx network	20% up to $200 max. copay/prescription; must use Aetna Specialty Rx network	$20 per prescription (30-day supply)	$30 per prescription
Supply Limit	30 days	30 days	100 days	30 days
Mail Order				
Value Drug List (chronic)	Plan pays 100% for Aetna Value Drug list	Plan pays 100% for Aetna Value Drug list	Plan pays 100%	Plan pays 100%
Preferred Generic	$30 per prescription	$30 per prescription	$10 per prescription	$20 per prescription
Preferred Brand	$50 per prescription	$50 per prescription	$20 per prescription	$60 per prescription
Non-Preferred Generic and Brand	$80 per prescription	$80 per prescription	$20 per prescription	$60 per prescription
Specialty Drugs	See Above	See Above	$20 per prescription (30-day supply)	Not Covered
Supply Limit	90 days	90 days	100 days	100 days

This summary is intended as a quick reference not a comprehensive description. For more plan information, please go to Benefits Employee's website at www.smcgov.org

Comparison of PPO Plans

	Aetna OAMC PPO Plan ($200 Deductible)		Aetna OAMC PPO Plan ($300 Deductible)	
	Note: OAMC is equivalent to a PPO in Aetna's Network			
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Annual Deductible Individual Family	$200 (individual) $600 (family)	$500 (individual) $1,000 (family)	$300 (individual) $900 (family)	$300 (individual) $900 (family)
Annual Out-of-Pocket Max Individual	$2,000	$4,000	$2,000	$3,000
Family	$4,000	$8,000	$4,000	$6,000
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited
Physician/Professional Services				
Office Visits PCP & Specialist	Plan pays 80%	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Telemedicine	Plan pays 80%	Not Covered	Plan pays 80% after deductible	Not Covered
Preventive Services	Plan pays 100%	Plan pays 60% after deductible	Plan pays 100%	Plan pays 60% after deductible
Chiropractic and Acupuncture Care (visit limits apply)	Chiro = Plan pays 80% after deductible Acupuncture = Plan pays 80%	Chiro = Plan pays 60% after deductible Acupuncture = Plan pays 60% after deductible	Chiro = Plan pays 80% after deductible Acupuncture = Plan pays 80% after deductible	Chiro = Plan pays 60% after deductible Acupuncture = Plan pays 60% after deductible
Lab and X-ray	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Infertility (Please refer to the EOC for additional details)				
Diagnosis and treatment of infertility	Diagnosis and treatment of the underlying medical condition only. (Your cost sharing is based on the type of service and where it is performed)	Diagnosis and treatment of the underlying medical condition only. (Your cost sharing is based on the type of service and where it is performed)	Diagnosis and treatment of the underlying medical condition only. (Your cost sharing is based on the type of service and where it is performed)	Diagnosis and treatment of the underlying medical condition only. (Your cost sharing is based on the type of service and where it is performed)
Assisted reproductive technology ("ART") Services	Not Covered	Not Covered	Not Covered	Not Covered

This summary is intended as a quick reference not a comprehensive description. For more plan information, please go to Benefits Employee's website at www.smcgov.org

Comparison of PPO Plans

UNDER 65

	Aetna OAMC PPO Plan ($200 Deductible)		Aetna OAMC PPO Plan ($300 Deductible)	
	Note: OAMC is equivalent to a PPO in Aetna's Network			
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Family Planning				
Physicians Family Planning Services	Plan pays 100%	Plan pays 60% after deductible	Plan pays 100%	Plan pays 60% after deductible
Vasectomy	Cost shared based on where performed	Not Covered	Cost shared based on where performed	Not Covered
Tubal Ligation	Plan pays 100%	Plan pays 60% after deductible	Plan pays 100%	Plan pays 60% after deductible
Hospital Services				
Inpatient Hospitalization	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 100% after deductible	Plan pays 70% after deductible
Outpatient Surgery	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 100% after deductible	Plan pays 70% after deductible
Urgent Care	Plan pays 100%	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency Room	$100 copay (waived if admitted)		Plan pays 100% (deductible waived)	
Mental Health Services				
Inpatient Hospital	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 100% after deductible	Plan pays 70% after deductible
Outpatient	Plan pays 80%	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Substance Abuse Services				
Inpatient Hospital	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 100% after deductible	Plan pays 70% after deductible
Residential Care	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 100% after deductible	Plan pays 70% after deductible
Outpatient	Plan pays 80%	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible

Comparison of PPO Plans

UNDER 65

	Aetna OAMC PPO Plan ($200 Deductible)		Aetna OAMC PPO Plan ($300 Deductible)	
	Note: OAMC is equivalent to a PPO in Aetna's Network			
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
Other Services				
Transgender	Covered (see plan document for limitations)	Covered (see plan document for limitations)	Covered (see plan document for limitations)	Covered (see plan document for limitations)
Durable Medical Equipment	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Orthotic and Prosthetic Devices	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 80% after deductible	Plan pays 60% after deductible
Skilled Nursing Facility Up to 100 days per Member, per Benefit Period	Plan pays 80% after deductible	Plan pays 60% after deductible	Plan pays 100% after deductible	Plan pays 70% after deductible

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Comparison of PPO Plans

Aetna OAMC PPO HDHP Plan
Note: OAMC is equivalent to a PPO in Aetna's Network

	In-Network	Out-Of-Network
Annual Deductible Individual Family	$1,600 (individual) $3,200 (individual w/in family) $3,200 (family)	$3,000 (individual) $3,000 (individual w/in family) $6,000 (family))
Annual Out-of- Pocket Max Individual	$3,200 (individual) $3,200 (individual w/in family)	$6,000 (individual) $6,000 (individual w/in family)
Family	$6,400 (family)	$12,000 (family)
Lifetime Max	Unlimited	Unlimited
Physician/Professional Services		
Office Visits PCP & Specialist	Plan pays 90% after deductible	Plan pays 60% after deductible
Telemedicine	Plan pays 90% after deductible	Not Covered
Preventive Services	Plan pays 100%	Not covered
Chiropractic and Acupuncture Care (visit limits apply)	Chiro = Plan pays 90% after deductible Acupuncture = Plan pays 90% after deductible	Chiro = Plan pays 50% after deductible Acupuncture = Plan pays 60%
Lab and X-ray	Plan pays 90% after deductible	Plan pays 60% after deductible
Infertility (Please refer to the EOC for additional details)		
Diagnosis and treatment of infertility	Diagnosis and treatment of the underlying medical condition only. (Your cost sharing is based on the type of service and where it is performed)	Diagnosis and treatment of the underlying medical condition only. (Your cost sharing is based on the type of service and where it is performed)
Assisted reproductive technology ("ART") Services	Not Covered	Not Covered

This summary is intended as a quick reference not a comprehensive description. For more plan information, please go to Benefits Employee's website at www.smcgov.org

Comparison of PPO Plans

UNDER 65

Aetna OAMC PPO HDHP Plan

Note: OAMC is equivalent to a PPO in Aetna's Network

	In-Network	Out-Of-Network
Family Planning		
Physicians Family Planning Services	Plan pays 100%	Not covered
Vasectomy	Plan pays 90% after deductible	Not covered
Tubal Ligation	Plan pays 100%	Plan pays 60% after deductible
Hospital Services		
Inpatient Hospitalization	Plan pays 90% after deductible	Plan pays 60% after deductible
Outpatient Surgery	Plan pays 90% after deductible	Plan pays 60% after deductible
Urgent Care	Plan pays 90% after deductible	Plan pays 60% after deductible
Emergency Room	Plan pays 90% after deductible	
Mental Health Services		
Inpatient Hospital	Plan pays 90% after deductible	Plan pays 60% after deductible
Outpatient	Plan pays 90% after deductible	Plan pays 60% after deductible
Substance Abuse Services		
Inpatient Hospital	Plan pays 90% after deductible	Plan pays 60% after deductible
Residential Care	Plan pays 90% after deductible	Plan pays 60% after deductible
Outpatient	Plan pays 90% after deductible	Plan pays 60% after deductible

Comparison of PPO Plans

UNDER 65

Aetna OAMC PPO HDHP Plan

Note: OAMC is equivalent to a PPO in Aetna's Network

	In-Network	Out-Of-Network
Other Services		
Transgender	Covered (see plan document for limitations)	Covered (see plan document for limitations)
Durable Medical Equipment	Plan pays 90% after deductible	Plan pays 60% after deductible
Orthotic and Prosthetic Devices	Plan pays 90% after deductible	Plan pays 60% after deductible
Skilled Nursing Facility	Plan pays 90% after deductible Up to 60 days per Member, per Benefit Period	Plan pays 60% after deductible Up to 60 days per Member, per Benefit Period

This summary is intended as a quick reference not a comprehensive description. For more plan information, please go to Benefits Employee's website at www.smcgov.org

Prescription Drugs

UNDER 65

Aetna

Aetna OAMC PPO Plan ($200 Deductible) **Aetna OAMC PPO Plan ($300 Deductible)**

Note: AOMC is equivalent to a PPO in Aetna's Network

	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Pharmacy				
Plan Deductible Applies?	No	No	No	No
Aetna Value Drug List	Plan pays 100%	25% to $250 max. copay per prescription	Plan pays 100%	25% to $250 max. copay per prescription
Preferred Generic	$15 per prescription	25% to $250 max. copay per prescription	$10 per prescription	25% to $250 max. copay per prescription
Preferred Brand	$30 per prescription	25% to $250 max. copay per prescription	$20 per prescription	25% to $250 max. copay per prescription
Non-Preferred Generic and Brand	$45 per prescription	25% to $250 max. copay per prescription	$35 per prescription	25% to $250 max. copay per prescription
Specialty (must use Aetna's Specialty Rx network)	20% to $100 max. copay per prescription	Not Covered	30% to $150 max. copay per prescription	Not Covered
Supply Limit	30 days	30 days	30 days	30 days
Mail Order				
Plan Deductible Applies?	No	No	No	No
Value Drugs (chronic)	Plan pays 100%	Not Covered	Plan pays 100%	Not Covered
Preferred Generic	$30 per prescription	Not Covered	$20 per prescription	Not Covered
Preferred Brand	$60 per prescription	Not Covered	$40 per prescription	Not Covered
Non-Preferred Generic and Brand	$90 per prescription	Not covered	$70 per prescription	Not covered
Specialty	20% to $100 max. copay/prescription	Not covered	30% to $150 max. copay/prescription	Not covered
Supply Limit	90 days	Not applicable	90 days	Not applicable

This summary is intended as a quick reference not a comprehensive description. For more plan information, please go to Benefits Employee's website at www.smcgov.org

Prescription Drugs

UNDER 65

Aetna

OAMC PPO HDHP Plan

Note: AOMC is equivalent to a PPO in Aetna's Network

	In-Network	Out-Of-Network
Pharmacy		
Plan Deductible Applies?	Yes	Yes
$0 Chronic Drug List	Plan pays 100%	25% to $250 max. copay per prescription
Preferred Generic	$10 per prescription	25% to $250 max. copay per prescription
Preferred Brand	$25 per prescription	25% to $250 max. copay per prescription
Non-Preferred Generic and Brand	$40 per prescription	25% to $250 max. copay per prescription
Specialty (must use Aetna's Specialty Rx network)	30% up to $200 max. copay per prescription	Not Covered
Supply Limit	30 days	30 days
Mail Order		
Plan Deductible Applies?	Yes	Yes
Value Drugs (chronic)	Plan pays 100% for Aetna Drug list	Not Covered
Preferred Generic	$20 per prescription	Not covered
Preferred Brand	$50 per prescription	Not covered
Non-Preferred Generic and Brand	$80 per prescription	Not covered
Specialty	20% to $100 max. copay/prescription	Not covered
Supply Limit	90 days	Not applicable

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Comparison of Health Plans

OVER 65

MEDICAL BENEFITS	AETNA MEDICARE® ADVANTAGE PPO **This PPO plan provides the maximum flexibility to see ANY provider who accepts Medicare ** Within Aetna Network and Accepts Medicare	AETNA MEDICARE® ADVANTAGE PPO **This PPO plan provides the maximum flexibility to see ANY provider who accepts Medicare ** Outside Aetna Network and Accepts Medicare	KAISER PERMANENETE SENIOR ADVANTAGE
Deductible	None		None
Maximum Annual Out of Pocket Maximum	$1,500 per person		$1,500 per person $3,000 per family
Service Area	Nationwide. Emergency Care Worldwide		Limited to Kaiser Permanente medical facilities service areas. Worldwide in emergency only.
Choice of Doctors and Hospitals	Any provider or facility who accepts Medicare		Limited to Kaiser-Permanente doctors and hospitals except in emergency.
Inpatient/Room & Board Outpatient Surgery Emergency Room	Covered in full $10 copay $20 (waived if admitted)	Covered in full $10 copay $20 (waived if admitted)	Covered in full $10 per procedure $20 (waived if admitted)
Hospice Care	Provided any Medicare-certified hospice program.	Provided any Medicare-certified hospice program.	Provided by licensed hospice approved by the medical group and certified by Medicare.
Skilled Nursing Facility (SNF)	Covered in full (days 1-100) for each stay in a Medicare- certified nursing facility. There is a limit for 100 days for each benefit period. If you go over the 100-day limit, you will be responsible for all costs	Covered in full (days 1-100) for each stay in a Medicare- certified nursing facility. There is a limit for 100 days for each benefit period. If you go over the 100-day limit, you will be responsible for all costs	Covered in full up to 100 days per benefit period.

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Comparison of Health Plans

OVER 65

MEDICAL BENEFITS	Aetna MEDICARE ADVANTAGE PPO **This PPO plan provides the maximum flexibility to see ANY provider who accepts Medicare **		KAISER PERMANENETE SENIOR ADVANTAGE
	Within Aetna Network and Accepts Medicare	Outside Aetna Network and Accepts Medicare	
Physician Care	$10 copay Primary Care Physician $20 copay Specialists	$10 copay Primary Care Physician $20 copay Specialists	$10 per office visit
Preventive Care (including annual gynecological exams and mammograms)	Medicare assigned providers: Covered in full	Medicare assigned providers: Covered in full	Covered in full.
Vision (Optical)	Medicare Covered: $20 copay Non-Medicare Covered: $10 copay ($150 combined allowance for lenses & frames every 24 months)	Medicare Covered: $20 copay Non-Medicare Covered: $10 copay ($150 combined allowance for lenses & frames every 24 months)	$10 per exam $150 combined allowance for lenses & frames every 24 months
Dental Care	Not covered	Not covered	Not covered
Hearing Services	Medicare Covered: $20 copay per visit Discount on hearing aids Non-Medicare Covered: $0 copay (One per 12 months)	Medicare Covered: $20 copay per visit Discount on hearing aids Non-Medicare Covered: $0 copay (One per 12 months)	Routine Exam: $10 copay Hearing Aids: Not covered
Acupuncture	For Medicare covered: $15 copay, 12 visits in 90 days): Non-Medicare covered: $15 copay up to 20 visits a year	For Medicare covered: $15 copay, 12 visits in 90 days): Non-Medicare covered: $15 copay up to 20 visits a year	$15 copay 20 combined visits
Chiropractic	For Medicare covered: $15 copay Non-Medicare covered: $15 copay up to 20 visits/year	For Medicare covered: $15 copay Non-Medicare covered: $15 copay up to 20 visits/year	
Prescriptions	***Please see next page***		**Retail:** $10 per prescription 100 day supply for most maintenance medications.

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OVER 65

PRESCRIPTION DRUG BENEFITS

aetna™ medicare solutions

	Retail (30-day supply)	Retail/Mail Order (90-day supply)
Stage 1: Annual Prescription Deductible	No deductible, this payment stage doesn't apply.	
Stage 2: Initial Coverage	You pay the following until your total out-of pocket drug costs reach **$5,030**	
Tier 1: Generic	Preferred Pharmacy: $9 Copay Standard Pharmacy: $10 copay	Preferred Pharmacy: $18 Copay Standard Pharmacy: $20 copay
Tier 2: Preferred Brand	$20 copay	$40 copay
Tier 3: Non-Preferred Brand	$35 copay	$60 copay
Tier 4: Specialty	30% coinsurance (up to a $150 copay max) per prescription	Not covered
Stage 3: Coverage Gap Stage	Because there is no coverage gap for the plan, this payment stage does not apply to you.	
Stage 4: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail service) reach **$8,000**, your share of the cost for a covered drug will be **$0**.	

Enhanced Services

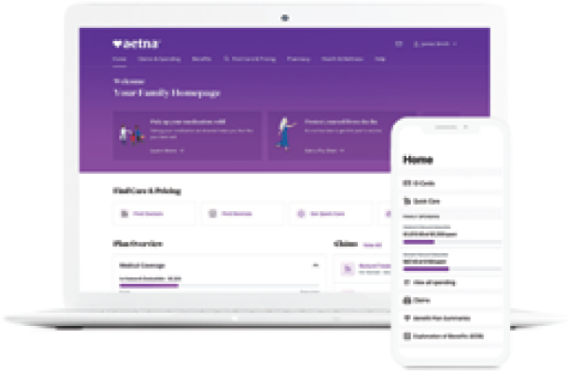
MOBILE APP

The Aetna® member website and Aetna Health™ app provide members enhanced 24/7 service and ease-of-access to the information that matters most. As a member of Aetna, with the app you can:

Manage your benefits, connect to care, handle claims — from anywhere..

As a member, you can:

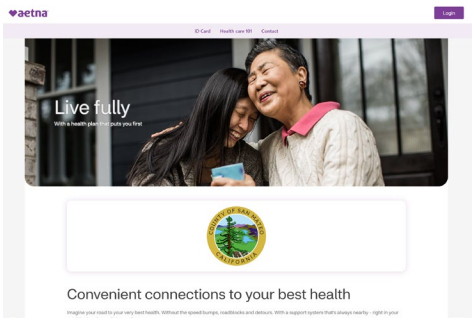
- View your health plan summary and get information about what's covered
- Track spending and progress toward your deductible or maximums for you and your family
- View and pay claims, and even see the breakdown of your costs, like what's covered by your plan and what you're responsible for



- Use tools to help you choose quality in-network providers
- Get personalized reminders to help improve your health

MICROSITE

Access all the information you need in one convenient place – paper-free and online. Get the best out of your benefits – visit [www.aetnaresource.com/p/cosmretiree.](www.aetnaresource.com/p/cosmretiree)



NO COST/LOW COST MINUTECLINIC®

Sometimes things just happen. You develop flu symptoms after your primary care office has closed for the day. You step on a tack over the weekend. Whatever it is, you want to be able to access care at a price you can afford. That's why we offer a perk to Aetna® members: access to covered MinuteClinic® services at no cost to you, or low cost to you, based on your plan.

** OAMC PPO HDHP members must first satisfy the plan deductible*.

CONDITION MANAGEMENT PROGRAMS

Get healthy now. Receive the help of an Aetna nurse who will act as your health coach. Our health programs come at no extra cost to you — they're part of your plan!

Enhanced Services

AETNA BACK & JOINT CARE PROGRAM

Through the Aetna Back and Joint Care Program, Hinge Health offers digital exercise therapy programs designed to address acute and chronic back, knee, hip, neck and shoulder pain. There is also a downloadable prevention program tailored to your needs.

Teladoc®

24/7 access to quality care

After hours? Can't get to the doctor's office? Teladoc connects you with board-certified doctors anytime. They can treat many non-emergency medical issues by phone or video. This may help you avoid urgent care and emergency room visits, which can be costly and time-consuming. And it's easy to use — you can speak to a doctor "on demand" in minutes. Or just schedule a time that's more convenient for you. You can request visits by either:

- Going to **Teladoc.com/Aetna**
- Downloading the Teladoc app

Visit **Teladoc.com/Aetna** to find out more and set up your account.

FOR AETNA MEDICARE ADVANTAGE PPO MEMBERS

SilverSneakers

Members who want to be fit and active have access to SilverSneakers. SilverSneakers is a lifestyle program that can improve your overall health and well-being

- Membership at thousands of participating gym locations
- Home fitness kit for those who can't make it to local gyms
- On-Demand fitness classes from the comfort of your own home
- SilverSneakers Go app

Enhanced Services

aetna medicare solutions

FOR AETNA MEDICARE ADVANTAGE PPO MEMBERS

Healthy Home Visits

Have licensed health care professional come to your home to:

- Identify potential safety hazards
- Review your medications and medical family history
- Provide a holistic health screening
- And more!
- PLUS: Earn a $100 gift card for completing a Health Home Visit.

MD Live

Virtual behavioral health support with 24/7 appointment availability and no visit limits.
They are specially trained in issues that are common with senior adults like:

- Addictions
- Grief and Loss
- Anxiety
- Loneliness
- Stress Management
- And more!

Non Emergency Transportation

Safe, comfortable transportation to and from medical appointments

- 24 annual rides are included in your plan at no extra cost for medical appointments within 60 miles
- A round trip is considered 2 rides

Meal Home Delivery Program

Get meals at home while you recover following an inpatient hospital stay at no extra cost

- 14 healthy, precooked meals
- Caters to special dietary needs including diabetic, vegetarian, and pureed foods
- Meals delivered within 48-72 hours

Enhanced Services

KAISER PERMANENTE®

Get the care you need the way you want it. No matter which option you choose, your providers can see your health history, update your medical record, and give you personalized care that fits your life.

24/7 care advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider.

In-person visit

Same-day appointments are often available. Sign on to kp.org anytime, or call us to schedule a visit.

Email

Message your doctor's office with non-urgent questions anytime. Sign on to kp.org or use our mobile app.[2]

Phone appointment

Save yourself a trip to the doctor's office for minor conditions or follow-up care.[2,3]

Video visit

Meet face-to-face online with a doctor on your computer, smartphone, or tablet for minor conditions or follow-up care.[2,3]

E-visit

Get quick online care for common health problems.

Fill out a short questionnaire about your symptoms, and a physician will get back to you with a care plan and prescriptions (if appropriate) – usually within 2 hours.

Need care now?

Know before you go.

Urgent care

An urgent care need is one that requires prompt medical attention, usually within 24 or 48 hours, but is not an emergency medical condition.

This can include minor injuries, backaches, earaches, sore throats, coughs, upper-respiratory symptoms, and frequent urination or a burning sensation when urinating.

Emergency care

Emergency care[1] is for medical or mental health conditions that require immediate medical attention to prevent serious jeopardy to your health. Examples include chest pain or pressure, severe stomach pain that comes on suddenly, severe shortness of breath, and decrease in or loss of consciousness.

Call Kaiser Permanente anytime at 1-866-454-8855 (TTY 711) to make an appointment or to get care advice.

1If you believe you have an emergency medical condition, call 911 or go to the nearest hospital. For the complete definition of an emergency medical condition, please refer to your Evidence of Coverage or other coverage documents.

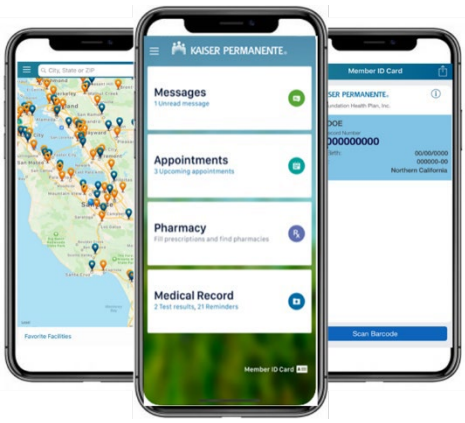
2 These features are available when you receive care at Kaiser Permanente facilities.

3 When appropriate and available.

Enhanced Services

KAISER PERMANENTE MOBILE APP

It's convenient and easy to use
Not sure if you need an appointment? Get advice, then schedule an appointment from the quick service menu.



- View and cancel appointments easily.
- Tap on the quick service menu to view your prescription list, then order refills or check the status of an order.
- See detailed medical record updates at a glance.
- Review your latest test results in an easy-to-read format.
- Send messages to your doctor or Member Services.
- Find a facility near you and get directions on the way

DIGITAL SELF CARE TOOLS

Everyone needs support for total health — mind, body, and spirit. Digital tools can help you navigate life's challenges, make small changes that improve sleep, mood, and more, or simply support an overall sense of well-being.

- Thoroughly evaluated by Kaiser Permanente clinicians
- Easy to use and proven effective
- Safe and confidential

Calm is the #1 app for meditation and sleep — designed to help lower stress, reduce anxiety, and more. Kaiser Permanente members can access all the great features of Calm at no cost, including:

- The Daily Calm, exploring a fresh mindful theme each day
- More than 100 guided meditations
- Sleep Stories to soothe you into deeper and better sleep
- Video lessons on mindful movement and gentle stretching

myStrength is a personalized program that helps you improve your awareness and change behaviors. Kaiser Permanente members can explore interactive activities, in-the-moment coping tools, community support, and more at no cost.

- Mindfulness and meditation activities
- Tailored programs for managing depression, stress, anxiety, and more
- Tools for setting goals and preferences, tracking current emotional states and ongoing life events, and viewing your progress

Adult Kaiser members can download these popululer apps at kp.org/selfcareapps.

The Calm app is not available to KP Washington members at this time.
myStrength is a wholly owened subsidiary of Livongo Health, Inc.

Enhanced Services

Silver&Fit® HEALTHY AGING AND EXERCISE PROGRAM

The Silver&Fit® Healthy Aging and Exercise Program is available to Kaiser Permanente Senior Advantage members. Since you don't have to be a lifelong athlete to be active as an older adult, this program makes it easier for you to get fit and stay motivated - **at no additional cost**.

You can choose your preferred exercise program:

Fitness Center Membership

Choose from Silver&Fit's broad network of participating fitness centers where you can:

- Workout with cardio and strength-training equipment
- Access their amenities such as saunas or pools
- Attend Silver&Fit classes including yoga, swimming, strength and cardio training, and more

Home Fitness Program

Kaiser makes it way to fit fitness into your day – right where you're most comfortable. With home fitness program, you'll get:

- Up to 2 home fitness kits each calendar year which may include an instructional DVD and printed guide, and one Stay Fit kit, which includes your choice of a Fitbit® or Garmin® wearable device, yoga kit or strength exercise kit
- Access to online exercise classes, Signature Series Classes at silverandfit.com

TO SIGN UP

Register at SilverandFit.com or call 1-877-750-2746 (TTY 711), Monday through Friday, 5am to 6pm Pacific Standard Time.

*** The Silver&Fit Program is provided by American Specialty Health Fitness., Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). The Silver&Fit program is available to current members of participating Kaiser Permanente Group Medicare health plans. ***

Voluntary Dental Benefits

The County offers two voluntary dental plans through Cigna for retirees: **DHMO and PPO plans.**

DENTAL HEALTH MAINTENANCE ORGANIZATION (DHMO)

Here's how a DHMO plan works. When you get a dental service, Cigna allows your network dentist to charge a certain amount. Then you **pay a fixed portion** of that cost, in addition to any allowable charge for upgraded materials (such as gold, high noble metal or porcelain used in molar restorations), complex rehabilitation or characterizations (for dentures). And your plan pays the rest. **There are no annual maximums and no deductibles**.

PREFERRED PROVIDER ORGANIZATION (PPO)

A Preferred Provider Organization (PPO) plan in which dental services are provided through the PPO network. You can choose any dentist in any location inside or outside of the Cigna network. How much you pay for dental services depends on how long you have worked for the County, your represented group, and whether you choose a participating Cigna dentist. If you choose a non-participating dentist, you pay the difference between the amount the dentist receives from Cigna (the "allowable amount") and the dentist's charges. Pre-authorization from Cigna is recommended for charges of $200 or more. Orthodontic treatment is not a covered service.

Cigna's Dental Care DHMO and Dental PPO plans have different networks. To check if your provider is in-network with the plan you want to enroll in please visit www.cigna.com or call Cigna.

- **Dental HMO Network: Cigna Dental Care Access Plus**
- **Dental PPO Network: Total Cigna DPPO**

Enrollment in any of the voluntary plans requires a 12-month calendar year enrollment period from January 2024 through December 2024

Voluntary Dental Plans

Dental Benefits	Cigna Dental HMO (Voluntary)	Cigna Dental PPO (Voluntary)	
Diagnostic and Preventive	**Member Pays:**	**In Network**	**Out of Network[1]**
Office Visit Teeth Cleaning X-Rays Sealants - *per tooth*	No Charge No Charge No Charge No Charge	No Charge	Plan Pays 80% (no deductible)
Restorative			
Amalgam Filling - *1-3 surfaces* Composite Filling - *1-3 surfaces*	No Charge No Charge	Plan Pays 80% (after deductible)	Plan Pays 70% (after deductible)
Periodontics			
Scaling and Root Planning - per quad Gingivectomy (Per Quadrant) Osseous Surgery	No Charge No Charge No Charge	Plan Pays 80% (after deductible)	Plan Pays 70% (after deductible)
Endodontics (Root Canal Therapy)			
Pulp Cap Therapeutic Pulpotomy Root Canal Therapy - (anterior, bicuspid, molar)	No Charge No Charge No Charge	Plan Pays 80% (after deductible)	Plan Pays 70% (after deductible)
Prosthodontics			
Immediate - Upper or Lower Complete - Upper or Lower Partial Denture - Upper or Lower	No Charge No Charge No Charge	Plan Pays 50% (after deductible)	Plan Pays 50% (after deductible)
Crown and Bridge			
Inlay / Onlay Crown - Porcelain/Ceramic Substrate Crown - Porcelain Fused to High Noble Metal Crown - Full Cast High Noble Metal	No Charge No Charge No Charge No Charge	Plan Pays 50% (after deductible)	Plan Pays 50% (after deductible)
Oral Surgery (Extractions)			
Impacted tooth: soft tissue Impacted tooth: partial bony Impacted tooth: full bony	No Charge No Charge No Charge	Plan Pays 80% (after deductible)	Plan Pays 70% (after deductible)
Implants			
Implants	Not Covered	Plan Pays 50%	Plan Pays 50%
Orthodontics - comprehensive			
Child Adult	No Charge No Charge	Not Covered	
Calendar Year Maximum			
Individual	N/A	$1,500	$1,500
Calendar Year Deductible			
Individual / Family	N/A	$50 / $150	

1 Based on Maximum Allowable Charge (In Network Fee Level)

Note: Enrollment in any of the voluntary plans requires a 12-month calendar year enrollment period from January 2024 - December 2024

This document is intended as a quick reference, not a comprehensive description. Limitations and exclusions can be found in the official plan documents. In case of any discrepancies, the official plan documents will govern.

Dental Plans

Dental Benefits	Cigna Dental PPO (Represented)		Cigna Dental PPO (Management)	
Diagnostic and Preventive	**In Network**	**Out of Network[1]**	**In Network**	**Out of Network[1]**
Office Visit Teeth Cleaning X-Rays Sealants - *per tooth*	Plan Pays 85%	Plan Pays 85%	Plan Pays 100%	Plan Pays 100%
Restorative				
Amalgam Filling - *1-3 surfaces* Composite Filling - *1-3 surfaces*	Plan Pays 85%	Plan Pays 85%	Plan Pays 100%	Plan Pays 100%
Periodontics				
Scaling and Root Planning - per quad Gingivectomy (Per Quadrant) Osseous Surgery	Plan Pays 85%	Plan Pays 85%	Plan Pays 100%	Plan Pays 100%
Endodontics (Root Canal Therapy)				
Pulp Cap Therapeutic Pulpotomy Root Canal Therapy - (anterior, bicuspid, molar)	Plan Pays 85%	Plan Pays 85%	Plan Pays 100%	Plan Pays 100%
Prosthodontics				
Immediate - Upper or Lower Complete - Upper or Lower Partial Denture - Upper or Lower	Plan Pays 85%	Plan Pays 85%	Plan Pays 100%	Plan Pays 100%
Crown and Bridge				
Inlay / Onlay Crown - Porcelain/Ceramic Substrate Crown - Porcelain Fused to High Noble Metal Crown - Full Cast High Noble Metal	Plan Pays 85%	Plan Pays 85%	Plan Pays 100%	Plan Pays 100%
Oral Surgery (Extractions)				
Impacted tooth: soft tissue Impacted tooth: partial bony Impacted tooth: full bony	Plan Pays 85%	Plan Pays 85%	Plan Pays 100%	Plan Pays 100%
Implants				
Implants	Plan Pays 50% Up to $1,000	Plan Pays 50% Up to $1,000	Plan Pays 100%	Plan Pays 100%
Orthodontics - comprehensive				
Child Adult	Not Covered		Not Covered	
Calendar Year Maximum				
Individual	$2,500	$2,500	None	
Calendar Year Deductible				
Individual / Family	None		None	

1 Based on Maximum Allowable Charge (In Network Fee Level)

Note: The opportunity to stay in a represented or management dental plan upon retirement is based on your Union's Memorandum of Understanding (MOU) or the Board Resolution.
If at any time you terminate this coverage, you will be waiving your right to return to this plan and will only have the option of enrolling in one of the Voluntary Plans.

This document is intended as a quick reference, not a comprehensive description. Limitations and exclusions can be found in the official plan documents. In case of any discrepancies, the official plan documents will govern.

Voluntary Vision Plan

VSP

More information about the VSP plan is available online at http://hr.smcgov.org/employee-benefits; click on Vision Plan.

Looking for the Perfect Pair?
Visit eyeconic.com!
VSP's online store lets you use apply your benefits directly to your purchase.

Vision Benefits	In Network	Out-of-Network Reimbursement
Exam Copay	$10	$10
Prescription Glasses Copay	$10	$10
Annual Eye Exam	Covered in Full	Up to $50
Single Lenses	Covered in Full	Up to $50
Standard Progressive Lenses	Covered in Full	Up to $85
Lined Bifocal Lenses*	Covered in Full	Up to $75
Lined Trifocal Lenses*	Covered in Full	Up to $100
Contacts Fit & Follow Up Exams	15% Discount, $60 copay (evaluation & fitting)	Allowance of $105 (applies to both contact lens exam and contact lenses)
Contact Lenses**		
Elective	Up to $150; 15% off over $150	Up to $105
Medically Necessary	Covered in Full	Up to $210
Frames	$150 Allowance; 20% off over $150 $80 Costco/Walmart/ Sam's Club frames	Up to $70
Benefit Frequency		
Exam	Every calendar year	
Lenses	Every calendar year	
Frames	Every other calendar year	

* Progressive bifocals may be purchased for the difference in cost

** Contact lenses are in lieu of spectacle lenses and frames

vsp vision care

Note: Enrollment in any of the voluntary plans requires a 12-month calendar year enrollment period from January 2024-December 2024

This document is intended as a quick reference, not a comprehensive description. Limitations and exclusions can be found in the official plan documents. In case of any discrepancies, the official plan documents will govern.

Monthly Cost of Health Benefit

HEALTH INSURANCE RATE FOR RETIREES UNDER 65

Monthly Health Insurance Rates for County Retirees
(effective January 1, 2024)

Health Insurance Rates for Retirees Under 65

	1/1/2024
AETNA FULL HMO	**monthly premium**
Employee Only	1,363.98
Employee +1	2,727.96
Employee + Family	3,860.06

AETNA AVN HMO	**monthly premium**
Employee Only	1,056.58
Employee +1	2,113.12
Employee + Family	2,990.08

AETNA HDHP OAMC PPO	**monthly premium**
Employee Only	1,127.84
Employee +1	2,255.68
Employee + Family	3,191.80

AETNA OAMC PPO ($200 Deductible)	**monthly premium**
Employee Only	1,739.92
Employee +1	3,613.74
Employee + Family	5,258.38

AETNA OAMC PPO ($300 Deductible)	**monthly premium**
Employee Only	1,363.98
Employee +1	2,727.96
Employee + Family	3,860.06

KAISER HMO	**monthly premium**
Employee Only	897.28
Employee +1	1,794.56
Employee + Family	2,539.30

KAISER HDHP	**monthly premium**
Employee Only	713.74
Employee +1	1,427.48
Employee + Family	2,019.88

Monthly Cost of Health Benefit

HEALTH INSURANCE RATE FOR RETIREES 65 AND OVER

Monthly Health Insurance Rates for County Retirees
(effective January 1, 2024)

Health Insurance Rates for Retirees 65 and Over

	1/1/2024
AETNA OAMC PPO ($200 Deductible) and MAPPO (Medicare)	**monthly premium**
Single - Retiree **with** Medicare	163.50
Two-Party - Both **with** Medicare	327.00
Two-Party - Ret **w/o** Medicare (PPO), Spouse **with** Medicare (PPO)	1,903.42
Two-Party - Ret **with** Medicare (PPO), Spouse w/o (PPO)	2,037.32
Family - Ret **with** Med (PPO) + Spouse and Child **without** (PPO)	3,681.96
Family - Ret **with** Med, Spouse **with** Medicare & Child(ren) **with** Medicare	490.50

AETNA FULL HMO and MAPPO (Medicare)	**monthly premium**
Two-Party - Ret **with** Medicare (PPO), Spouse w/o (HMO)	1,527.48
Two-Party - Ret w/o Medicare (HMO), Spouse with Medicare (PPO)	1,527.48
Family - Ret **with** Med (PPO) + Spouse and Child **without** (HMO)	2,659.58
Family - Ret & Spouse **with Med** (PPO) & Child **without** Medicare (HMO)	1,690.98

AETNA AVN HMO and MAPPO (Medicare)	**monthly premium**
Two-Party - Ret **with** Medicare (PPO), Spouse w/o (AVN HMO)	1,220.06
Two-Party - Ret w/o Medicare (AVN HMO), Spouse with Medicare (PPO)	1,220.06
Family - Ret **with** Med (PPO) + Spouse and Child **without** (AVN HMO)	2,097.00
Family - Ret & Spouse **with** (PPO) & Child **without** Medicare (AVN HMO)	1,383.56

AETNA OAMC PPO ($300 Deductible) and MAPPO (Medicare)	**monthly premium**
Two-Party - Ret **with** Medicare (PPO), Spouse w/o (OOA PPO)	1,527.48
Two-Party - Ret (OOA PPO) + Spouse **with** Medicare (PPO)	1,527.48
Family - Ret (OOA PPO) + Spouse **with** Medicare (PPO) + Child (OOA PPO)	2,891.46

Kaiser HMO (Senior Advantage Medicare Combo Rates)	**monthly premium**
Single - Subscriber **with** Medicare	343.05
Two-Party - Subscriber **with** Medicare & Spouse **with** Medicare	686.10
Two-Party - Subscriber **with** Medicare & Dependent **without** Medicare	1,240.23
Two-Party - Subscriber **without** Medicare & Spouse **with** Medicare	1,240.23
Family - Subscriber **with** Medicare & Children **without** Medicare	1,984.89
Family - Subscriber **with** Medicare, Spouse **without** Medicare, & Child **without** Medicare	1,984.89
Family - Subscriber **without** Medicare**,** Spouse **with** Medicare, and Child **without** Medicare	1,984.89
Family - Subscriber **with** Medicare, Spouse **with** Medicare, and Children **without** Medicare	1,430.76
Family - Subscriber **with** Medicare, Spouse **without** Medicare, and Children **without** Medicare	1,984.89
Family - Subscriber **without** Medicare, Spouse **with** Medicare, and Children **without** Medicare	1,984.89
Family - Subscriber **without** Medicare, Spouse **with** Medicare, and Children **with** Medicare	1,583.28
Family - Subscriber **with** Medicare, Spouse **with** Medicare, and Children **with** Medicare	1,029.15

Monthly Cost of Voluntary Dental & Vision Benefits

Dental Insurance Rates for Retirees

Voluntary Cigna Dental DHMO	1/1/2024 monthly premium
Single	27.63
Two-Party	46.97
Family	71.84

Voluntary Cigna Dental PPO	monthly premium
Single	41.48
Two-Party	79.86
Family	143.26

Vision Insurance Rates for Retirees

Voluntary VSP	1/1/2024 monthly premium
Single	8.83
Two-Party	17.65
Family	28.41

MANAGEMENT AND REPRESENTED DENTAL RATES

If your Represented Union or Board Resolution provides you the opportunity to stay in a represented or management dental plan upon retirement, you will be able to continue on this plan when your available sick leave credits expire.

You will be charged the regular rate for this coverage. If at any time you terminate this coverage, you will be waiving your right to return to this plan and will only have the option of enrolling in one of the Voluntary dental plans during the open enrollment period.

Dental Insurance Rates for Retirees

Cigna Dental DHMO	1/1/2024 monthly premium
Management	42.98
Represented	42.98

Cigna Dental PPO	monthly premium
Management	128.52
Represented	103.72

Vision Insurance Rates for Retirees

VSP-Management	1/1/2024 monthly premium
Composite Rate	16.02

Monthly Cost of Health Benefit

OPERATING ENGINEERS

Monthly Health Insurance Rates for County Retirees
(effective January 1, 2024)

Health Insurance Rates for Retirees Under 65

	1/1/2024
OPERATING ENGINEERS PPO, DENTAL & VISION	**monthly premium**
Employee Only	1157.00
Employee +1	2314.00
Employee + Family	3124.00
OPERATING ENGINEERS KAISER, DENTAL & VISION	**monthly premium**
Employee Only	1,032.00
Employee +1	2,064.00
Employee + Family	2,692.00

Health Insurance Rates for Retirees 65 and Over

	1/1/2024
OPERATING ENGINEERS PPO (Medicare)	**monthly premium**
Single - Subscriber **with** Medicare	1,029.00
Two-Party - Subscriber **with** Medicare & Spouse **with** Medicare	2,057.00
Family - Subscriber **with** Medicare, Spouse **with** Medicare, and Children **with** Medicare	2,777.00
OPERATING ENGINEERS KAISER (Medicare)	**monthly premium**
Single - Subscriber **with** Medicare	451.00
Two-Party - Subscriber **with** Medicare & Spouse **with** Medicare	901.00
Family - Subscriber **with** Medicare, Spouse **with** Medicare, and Children **with** Medicare	1,334.00

Retiree Billing Process with BCC

Thirty (30) days before you officially retire, you should meet with a Benefits Partner to complete your retiree paperwork which will include (among others) the Retiree Enrollment Form and BCC Electronic Fund Transfer Form (EFT).

*If retiring at 65 years of age or over, contact the Benefits Division 90 days before you officially retire.

WHAT TO EXPECT FROM BCC:

1. Last business day of the month, pension funds are deposited your bank account.
2. On the last business day of the coverage month, BCC will pull funds from your bank account for premium payment of benefits.
3. Use your bank statement as confirmation of payment.
4. Changes to banking accounts must be provided to BCC Customer Service at 800-685-6100 or to the Benefits Division at benefits@smcgov.org.

Preventive Care Screening Benefits

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, gender and medical history. Visit **cdc.gov/prevention** for recommended guidelines. **Preventive care is covered in full only when obtained from an IN-NETWORK provider.**

Not all exams and tests are considered preventive

Exams performed by specialists are not generally considered preventive and may not be covered at 100 percent. Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services. If you have a question about whether a service will be covered as preventive care, contact your medical plan.

TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer
- Depression
- STIs

Preventive care for women should include breast and gynecological exams

For men, preventive care should include prostate cancer screening and a testicular exam

Should I skip my checkup due to COVID-19?

Staying safe from the coronavirus doesn't necessarily mean skipping preventive healthcare. Talk to your doctor about whether you need a checkup right away or can delay until there is a lower risk of being exposed to COVID-19. Depending on your medical needs, you may be treated with a combination of telehealth and in-person care.

Consider scheduling a flu shot when they're available to avoid a potential combined infection of COVID-19 and the flu. And, of course, seek medical care right away if you have symptoms that need immediate attention. Nearly every doctor's office has added new practices to ensure the safety of patients, providers and other employees.

Health and Wellness

The Wellness Program is designed to promote your health and well-being through a variety of health, fitness and educational programs, services and activities. By empowering retirees with health education and lifestyle skills, the Wellness Program plays a pivotal role in adopting a healthy lifestyle not just to live a long life, but a quality life where each person continues to be engaged and connected with others.

As a County retiree, you are encouraged to be proactive and take good care of your health. You can attend most health programs and classes at little or no cost to you. Listed below are the wellness programs that you can participate in:

Wellness Classes & Services

· Group Exercises Classes
· Mental Wellbeing Classes
· Nutrition Classes
· Physical Activity Classes
· Physical Activity Team Challenges
· Weight Loss Team Challenges
· Onsite Massage Therapy

Health Improvement Classes & Services

· Diabetes & Pre-diabetes Prevention Classes
· Heart Healthy Classes
· Mindfulness Meditation

Special Events/Community Outreach

· Blood Drives
· Farmers Market
· Health Club Information and Discounts
· Recreation tournaments: Basketball, Bowling, Soccer, Softball, Volleyball…

Health and Wellness

aetna™

Well-Being Tools

Your good health starts here. Your health goals lead the way. Wherever they take you, we'll keep finding new ways to join you – with the latest information and inspiration to support you in your journey. Log into your Aetna Health Member Website at www.aetna.com today to get started.

Live your healthiest ... with a helping hand

Now you can work with a wellness coach to improve the way you feel. On your schedule. And at no extra cost. This program helps you tackle your top health concerns, like:

- Getting to or staying at a healthy weight
- Stopping smoking
- Eating healthier
- Exercising more
- Taking care of stress

Plus, our wellness coaches help you practice mindfulness, so you can tune into your body's cues and take better care of yourself, inside and out.

Member Discounts

Save on a variety of expenses, including eye care, fitness, weight management, dental care, senior wellness and nutrition services.

To access these and more log into your Aetna Health Member Website at www.aetna.com.

KAISER PERMANENTE®

Wellness Programs

Complimentary programs can help you:

- Lose weight
- Eat healthier
- Quit smoking
- Reduce stress
- Manage ongoing conditions like diabetes or depression

kp.org/healthylifestyles

Member Discounts

Get reduced rates on a variety of health-related products and services through The ChooseHealthy® program. These include:

- Active&Fit Direct — members pay $25 per month (plus a one-time $25 enrollment fee) for access to a national network of more than 10,000 fitness centers
- Up to 25% off a contracted provider's regular rates for:
  - Acupuncture
  - Chiropractic care
  - Massage therapy

kp.org/choosehealthy

Health Classes

With all kinds of health classes and support groups offered at Kaiser facilities, there's something for everyone. Classes vary at each location, and some may require a fee.
kp.org/classes

CLASSPASS IS AVAILABLE!

With gym closures and physical distancing, it can be a challenge to stay physically and mentally healthy right now. ClassPass is a popular fitness membership program that provides access to thousands of different studios, gyms, and wellness offerings, both in-person and virtually.

Members can get:

- **Online video workouts at no cost** — 4,000+ on-demand fitness classes, including cardio, dance, meditation, and more.
- **Discounts on livestream fitness classes** — Real-time online classes, like bootcamp, yoga, and Pilates, from top gyms and fitness studios.

To get started with ClassPass and explore other fitness deals offered to our members, go to kp.org/exercise.

Additional Voluntary Benefits

AlliantCHOICE plus

You can sign up for this program any time throughout the year!

NATIONWIDE INSURANCE

Pet insurance protects your pet's health—and your budget. Your pet will have coverage for check-ups, accidents or illnesses, and significant medical problems – depending on the plan you choose. Plus, you'll have your choice of vets worldwide.

You can enroll for **My Pet Protection®** and **My Pet Protection with Wellness®.** All members receive free access to Vet Helpline, 24/7 telephone access to veterinary experts who can provide pet health guidance, answer general questions and identify urgent care needs.

You're not limited to just a few providers—you can visit any veterinarian worldwide.

Nationwide is on your side

URL: www.petinsurance.com/cosmretirees
Phone Number: 844.208.1108

IMPORTANT REMINDERS:

- When calling Nationwide, identify yourself as a **County of San Mateo Retiree** to take advantage of County rates and discounts.
- ***Two policies are offered: one with basic coverage and another with expanded Wellness features for your pet.***
- ***Multi-pet discounts are available.***
- There is a 14-day waiting period from date of application and payment of premium.
- Premium payments can be made via check, EFT, or credit card. Some fees may apply.
- 2 months of premium payment is required at time of enrollment.
- Please note that the County of San Mateo does not administer these plans.
- For plan information and administration, please contact Nationwide directly.

AlliantCHOICE plus

You can sign up for this program any time throughout the year!

AUTO & HOME INSURANCE

Great news! You now have more options for your Auto & Home Insurance with InsureOne Premier

The County of San Mateo has selected InsureOne for your auto and home insurance needs. The InsureOne Premier program gives you access to an online quoting platform, dedicated service team, and experienced California agents who will compare insurance quotes across the many carriers.

Starting on 1/1/24, retirees can call AlliantCHOICE Plus at **833-634-7132** to connect with InsureOne.

Please note, the Auto & Home program through Farmers, Liberty Mutual, and Travelers will end on 12/31/23. Retirees can continue to get quotes through these three carriers through December 2023.

Key Carrier Contacts At-A-Glance

AETNA AVN, HMO & OAMC PLANS CONCIERGE		
Control/Group #187677	www.aetnaresource.com/p/cosmretiree	(833) 576-2494
AETNA MEDICARE ADVANTAGE PPO (65+)		
Group #0014568 for the Medicare Advantage PPO plan	www.AetnaRetireePlans.com	Aetna Medicare PPO Customer Service Pre-Enrollment 800-307-4830 Post-Enrollment 888-267-2637
KAISER PERMANENTE SENIOR ADVANTAGE (65+) **TRADITIONAL HMO** (UNDER 65)		
Group #7056-**0005**	https://kp.org	(800) 464-4000
CIGNA DENTAL (DHMO & PPO)		
Group # 3340005	www.cigna.com	(800) 244-6224
VSP (VISION)		
Group #25600	www.vsp.com	(800) 877-7195
THE STANDARD (Life)		
Group #649107	www.standard.com	(800) 628-8600
EMPOWER (FORMERLY MASS MUTUAL) (Deferred Compensation)		
County of San Mateo	www.viewmyretirement.com/sanmateocounty	(800) 743-5274
SAN MATEO COUNTY EMPLOYEES' RETIREMENT ASSOCIATION (SamCERA – Pension)		
County of San Mateo	www.samcera.org	(650) 599-1234
AVIDIA BANK - HSA		
	www.avidiabank.com	(855) 248-6311 hsainfo@avidiabank.com
OTHER RESOURCES		
California Health Insurance Advocacy Program (HICAP)	Free help with Medicare benefits and long term care insurance, including counseling, advocacy and general information	(800) 434-0222 (650) 627-9350 (San Mateo office) www.cahealthadvocates.org
Medicare	Official government site with all your Medicare information	(800) MEDICARE www.medicare.gov

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children underage 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call your plan administrator.

Newborns' and Mothers' Health Protection Act

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

Notice of Choice Providers

The County of San Mateo allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, HMO plans designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the benefits division at 650-363-1919 or benefits@smcgov.org.

You do not need prior authorization from the carrier or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the benefits division at 650-363-1919 or benefits@smcgov.org.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in the County of San Mateo's health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in the County of San Mateo's health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31-day timeframe, coverage will be effective on the date of birth, adoption, or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in the County of San Mateo's health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.
Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan. Any other currently covered dependents may also switch to the new plan in which you enroll.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for the County of San Mateo describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting your plan administrator.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 8.39% in 2024 of your modified adjusted household income.

Notice of Availability of Alternative Standard for Wellness Plan

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at atwellness@smcgov.org and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Notice Regarding Wellness Program

County of San Mateo Wellness Dividend Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which would include a blood test for glucose, HDL, LDL, triglycerides and total cholesterol. You are not required to complete an HRA or to participate in any blood tests or other medical examinations.

However, employees who choose to participate in the wellness program will receive a cash incentive for completing a Health Risk Assessment, one MyPlan, and one Personal Wellness Plan on PreventionCloud. Although you are not required to complete an HRA or participate in any biometric screenings, only employees who do so will receive $500 - $750.

Wellness Basket prizes may be available for employees who participate in certain health-related activities such as physical activity challenges, completing surveys, attending Wellness Fair sessions. If you are unable to participate in any of the health-related activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Employee Wellness at wellness@smcgov.org.

The information from your HRA and/or the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

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

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

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

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.
If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Employee Wellness at wellness@smcgov.org.

Medicare Part D Notice

Important Notice from County of San Mateo 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 County of San Mateo and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1.Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2.County of San Mateo has determined that the prescription drug coverage offered by Kaiser Permanente, Aetna of California, and United Healthcare are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your County of San Mateo coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under the County of San Mateo are creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your County of San Mateo prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with County of San Mateo 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 [or call [the County of San Mateo Human Re-sources Department- Benefits Division at (650)363-1919. 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 County of San Mateo changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: January 1, 2024
Name of Entity: County of San Mateo
Contact: Human Resources- Benefits Division
Address: 455 County Center, 5th Floor Redwood City, CA 94063
Phone: (650) 363-1919

HIPAA PRIVACY NOTICE

COUNTY OF SAN MATEO PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

{The following summary section is optional, though suggested by HHS for a "layered notice" at 67 Fed. Reg. 53243

(Aug. 14. 2002) and 78 Fed. Reg. 5625 (Jan. 25, 2013).}

Summary of Our Privacy Practices

We may use and disclose your protected health information ("medical information"), without your permission, for treatment, payment, and health care operations activities. We may use and disclose your medical information, without your permission, when required or authorized by law for public health activities, law enforcement, judicial and administrative proceedings, research, and certain other public benefit functions.

We may disclose your medical information to your family members, friends, and others you involve in your care or payment for your health care. We may disclose your medical information to appropriate public and private agencies in disaster relief situations.

We may disclose to your employer whether you are enrolled or disenrolled in the health plans it sponsors. We may disclose summary health information to your employer for certain limited purposes. We may disclose your medical information to your employer to administer your group health plan if your employer explains the limitations on its use and disclosure of your medical information in the plan document for your group health plan.

Except for certain legally-approved uses and disclosures, we will not otherwise use or disclose your medical information without your written authorization.

You have the right to examine and receive a copy of your medical information. You have the right to receive an accounting of certain disclosures we may make of your medical information. You have the right to request that we amend, further restrict use and disclosure of, or communicate in confidence with you about your medical information.

You have the right to receive notice of breaches of your unsecured medical information.

Please review this entire notice for details about the uses and disclosures we may make of your medical information, about your rights and how to exercise them, and about complaints regarding or additional information about our privacy practices.

For more information about our privacy practices, to discuss questions or concerns, or to get additional copies of this notice contact:

Office: Benefits Division

Telephone:(650) 363-1919

E-mail: benefits@smcgov.org

Address: 455 County Center 5th Floor Redwood City,CA 94063

NON DISCRIMINATORY TESTING FOR CAFETERIA PLANS GOVERNED UNDER CODE SECTION 125

IRS requires each plan governed under “Code Section 125 cafeteria plans” to go through non-discriminatory testing each plan year to see if our plan passes. These plans offer a favorable pre-tax benefit and the IRS requires plans to conduct special non-discriminatory testing on all plans that offer a favorable pre-tax benefit each year.

The codes nondiscrimination rules exist to prevent plans from being designed in such a way that it discriminates in favor of individuals who are either highly compensated employees or are otherwise key employees in the organization.

The plans will not pass the tests if the highly compensated employees or key employees elect more benefits under the plan than employees who are not highly compensated. This is called a “Concentration Test”. If plans fail the concentrations testing, adjustments may be required to the yearly election amounts. Adjustments will not be made if the plan passes.

MODEL COBRA CONTINUATION COVERAGE ELECTION NOTICE

(FOR USE BY SINGLE-EMPLOYER GROUP HEALTH PLANS)

IMPORTANT INFORMATION: COBRA Continuation Coverage and other Health Coverage Alternatives
This notice has important information about your right to continue your health care coverage in the [enter name of group health plan] (the Plan), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided later in this notice.

WHY AM I GETTING THIS NOTICE?
You're getting this notice because your coverage under the Plan will end on [enter date] due to [check appropriate box]:

☐ End of employment
☐ Death of employee
☐ Entitlement to Medicare
☐ Reduction in hours of employment
☐ Divorce or legal separation
☐ Loss of dependent child status

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

WHAT'S COBRA CONTINUATION COVERAGE?
COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

WHO ARE THE QUALIFIED BENEFICIARIES?
Each person ("qualified beneficiary") in the category(ies) checked below can elect COBRA continuation coverage:

☐ Employee or former employee
☐ Spouse or former spouse
☐ Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
☐ Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

IF I ELECT COBRA CONTINUATION COVERAGE, WHEN WILL MY COVERAGE BEGIN AND HOW LONG WILL THE COVERAGE LAST?

If elected, COBRA continuation coverage will begin on the first of the month following your separation from the County and can last for eighteen (18) months.

Continuation coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

CAN I EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE?
If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify [enter name of party responsible for COBRA administration] of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage visit https://www.dol.gov/ebsa/publications/cobraemployee.html.

HOW MUCH DOES COBRA CONTINUATION COVERAGE COST?
COBRA continuation coverage will cost: [enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.]

Other coverage options may cost less. If you choose to elect continuation coverage, you don't have to send any payment with the Election Form. Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of this notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?
The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

WHEN CAN I ENROLL IN MARKETPLACE COVERAGE?
You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away. In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

IF I SIGN UP FOR COBRA CONTINUATION COVERAGE, CAN I SWITCH TO COVERAGE IN THE MARKETPLACE? WHAT ABOUT IF I CHOOSE MARKETPLACE COVERAGE AND WANT TO SWITCH BACK TO COBRA CONTINUATION COVERAGE?
If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if

you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended. If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

CAN I ENROLL IN ANOTHER GROUP HEALTH PLAN?
You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

WHAT FACTORS SHOULD I CONSIDER WHEN CHOOSING COVERAGE OPTIONS?
When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

FOR MORE INFORMATION
This notice doesn't fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact [enter name of party responsible for COBRA administration for the Plan, with telephone number and address].

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

IMPORTANT INFORMATION ABOUT PAYMENT

FIRST PAYMENT FOR CONTINUATION COVERAGE

You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all continuation coverage rights under the Plan. You're responsible for making sure that the amount of your first payment is correct. You may contact [enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan] to confirm the correct amount of your first payment.

PERIODIC PAYMENTS FOR CONTINUATION COVERAGE

After you make your first payment for continuation coverage, you'll have to make periodic payments for each coverage period that follows. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due [enter due day for each monthly payment] for that coverage period. [If Plan offers other payment schedules, enter with appropriate dates: You may instead make payments for continuation coverage for the following coverage periods, due on the following dates:]. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan [select one: will or will not] send periodic notices of payments due for these coverage periods.

GRACE PERIODS FOR PERIODIC PAYMENTS

Although periodic payments are due on the dates shown above, you'll be given a grace period of 30 days after the first day of the coverage period [or enter longer period permitted by Plan] to make each periodic payment. You'll get continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period.

If you don't make a periodic payment before the end of the grace period for that coverage period, you'll lose all rights to continuation coverage under the Plan. Your first payment and all periodic payments for continuation coverage should be sent to BCC.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ Phone: 1-866-251-4861 | Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 | State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid

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

INDIANA – Medicaid

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

IOWA – Medicaid and CHIP (Hawki)

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

KANSAS – Medicaid

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

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

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

MINNESOTA – Medicaid

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

MISSOURI – Medicaid

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

MONTANA – Medicaid

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

NEBRASKA – Medicaid

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

NEVADA – Medicaid

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

NEW HAMPSHIRE – Medicaid

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

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ | Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx or http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ | Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: http://www.greenmountaincare.org/ | Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select or https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 | CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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.

New Health Insurance Marketplace Coverage Optionsand Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 9-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact

_____

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

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

PART B: Information About Health Coverage Offered By Your Employer

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

3. Employer Name		4. Employer Identification Number (EIN)
COUNTY OF SAN MATEO		**94-6000532**
5. Employer address		6. Employer phone number
455 COUNTY CENTER		**(650) 363-1919**
7. City	8. State	9. ZIP Code
REDWOOD CITY	**CA**	**94063**
10. Who can we contact about employee health coverage at this job?		
BENEFITS DIVISION		
11. Phone number (if different from above)	12. Email address	
(650) 363-1919	**benefits@smcgov.org**	

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

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

  ☐ All employees. Eligible employees are:

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☐ We do offer coverage. Eligible dependents are:

  ☐ We do not offer coverage.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard?

☐ Yes (go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets minimum value standard offered only to the employee (don't include family plans):

If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets minimum value standard. (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $_____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Revised 10.3.23